Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ( Physician/ Meria 1030 ay Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death Spa Creek Center Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Months Hours Min 229-14-0807 1 M 2 M 2 107974922 Director 87 VA Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at. 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel Annapolis 1 Yes 2XX No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1042 Mt. Top Dr. 21409 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 1 No Yes, Give Maryland 21215-0036 1 ☐ Yes XX No Specify: White Completed 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Office Manager Dept. Social Services of and 2 should be filed wit of Health and Mental Hygie of item 27 is marked other i r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis Snow Webb Ethel Grantham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a Pamela Williams Daughter 1044 Little Magothy View Annapolis, MD 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or c 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lakemont Memorial 8/18/2010 Davidsonville, MD 21. Signature of Function Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. at. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death hysician. disease or condition resulting in death) Medical Due to (or as a con equence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Day Month Year 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide

Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 3 Ecrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29h and title of certifier \$ignatur address of person who completed cause of death (Item 23a) (Type, Print) Amapalis my 2140 State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 5:55 P M August 16, Ruby Clay Purdum 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick Memorial Hospital Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Year) Days Hours Min Months 1 □ M 2 ■ F Yrs. April 22,1925 Maryland 85 220-18-2374 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ■ No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 8705 Woodfield Court 20882 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 ■ No Specify: White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bank 12 Branch Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Warfield Joseph Clay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10456 Sweepstakes Road, Damascus, Maryland 20872 Charles Burdette/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Damascus 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Aug.20,2010 Damascus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Methodist Cemetery 21. Signature of Mneral Service Lighses 22. Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Inter the disease, or complicate in situat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a vause on each line. Onset and Death Immediate Cause (Final Intracerebral Hemorrhage disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ■ No 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ■ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

be executed Box 68760, law requires that the death certificate Ö ۵. Division of Vital Records, or Attending Physician:

Hospital

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, "the Modical Experience; wet the positions at

death with

72 hours after

d 2 should be filed within 7/s th and Mental Hygiene.
7 Is marked other than "n

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be.
Department of Health and Mental Important: If Imm 27 is merany injury or other. **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-tran Physician/Medical certificate has been signed by the rector, page 2 should be detached à Completed funeral director. Be 1 ☐ Yes 2 👿 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation s after death 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide ò 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MDD 62180

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7th 400 W

RizVi 1-auzi Year) 31. Date filed (Month. Day. AUG

32. Registrar's Signature

Frederick, MD 21701

16/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 DM Arlena Pannel1 August Medical a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Hospice of the Chesapeake Harwood If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 01/14/1943 Hours 1 M 2 K F 233-66-9551 67 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🛣 No MD Anne Arundel Deale 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 5 ms 23a or must be r Funeral United States 920 Main Street 20751 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. n "natural", or item ledic 1 Examiner π 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes Give Specify: Completed 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medic — any injury or other traumatic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Non-Profit Elementary/Seconday (0-12) College (1-4 or 5+) Organization 12 Axxounts Pavable Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Louanna Johnson Oran Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Pannell / Son 2400 Woodland Court, Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Rurial 2 X Cremation 3 Removal from State 08/21/2010 4 Donation 5 Other (Specify) Lee Crematory Clinton, MD of E neral Service Licer 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. any in 3. Goff 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure! List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EN DOMETRIUM Physician/ (ANCER mos disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the bunal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) Pregnant at time of death by the a Unknown 9 Unknown Division of Vital Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 27 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes cate has been signated bage 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Other: HC UJE 2 1 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ this hours after death.

Ineral Director: After this
of filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation ☐ Accident ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi DO811 AUBUST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dra 10 AMMORIS 21401

Registrar DHMH 17 Rev 7/2009

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Registra s Signature

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STANLAT 31. Date filed (Month, Day, Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ August 8, 2010 9:02 а м Gloria Parker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) February 1, 1927 Country MD Director 83 217-34-2123 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland Medical Examiner must be notified at Director 1 Tes 2 No Calvert Saint Leonard MD 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Number items 23a Funeral 20685 USA 6335 Broomes Island Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or 2 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3

Widowed 4 □ Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) perunt. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic encountries. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self employed Caregiver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ora V. Rice George W. Bourne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6295 Broomes Island Road, Saint Leonard, MD 20685 19a. Informant's Name/Relationship (Type, Print) Lucy Wallace - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 

✓ Burial 2 

Cremation 3 

Removal from State Southern Mem. Gardens : August 13, 2010 Dunkirk, MD 4 Donation 5 Other (Specify) Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1451 Dares Beach Rd., Prince Frederick, MD 20678 Glade 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 7eumon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ĮQ. in the past 12 months? Year Month Day Pregnant at time of death 2 JNO Yes the detached Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Nown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 🙀 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 욘 1 🗌 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pendina nours after death. neral Director: Af I filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 2000 m1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dew X EVSON

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Registrar

31. Date filed (Month, Day

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2010 Physician/ Augus 7 Richard Maurice Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and numb 4c. County of Death Examiner Easton emoria If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth cial Security Number Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 04-11-1953 Min. 1 🗷 M 2 🗆 F Director Marvl 215-58-5840 Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Md Cambridge Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 436 Leonard Lane 21613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. ğ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Dorchester Comm. College (1-4 or 5+) Elementary/Seconday (0-12) Delopment Carpentry Be 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) ပ Alfreda Beatrice Warner Richard Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Lane Cambridge Md. Brenda Fields / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 08-16-10 Bonatio 5 Other (Specify) Md. Veterans Cem. Hurlock, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover St., Easton, Md. 21601 23a. Part 1. Ententhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ disease or condition resulting in death) ) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): inding physician ause as the burial-Physician/Medical death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death a  $\square$  Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy performed? Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one)  $\mathbf{B}_{\mathbf{e}}$ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes ပ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Y Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of certifier 08-09-2010 D0059487 welselses 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOTSIS 3+VA JOHN Washington Street EASton, MAry land

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32. Registrar's Signatu

AUG 12

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARTHA VIRGINIA REEVES AUGUST 14 2010 6:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 206 CROCKER DRIVE, APT B BEL AIR HARFORD Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Funeral Days Hours Months 1 □ M 2X F 88 Yrs. 218-32-4753 JULY 9, 1922 Director MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 1X Yes 2 □ No Director MARYLAND HARFORD BEL AIR 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 206 CROCKER DRIVE, APT B 21014 UNITED STATES Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 PRODUCTION WORKER FOOD PACKAGING 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) RAYMOND RUFF, SR MARTHEA DAVIS ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ZELMA WARREN REEVES, SR/ SPOUSE 206 CROCKER DRIVE, APT B, BEL AIR, MARYLAND 21014 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CLARKS UNITED METH 08/20/10 BEL AIR, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, MD 21078 21. Signature of Funeral Service Licensee Scott- Col 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 105. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral L 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 56545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #106, BEL AIR RD W. MACPHAIL KHOSFA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

DHMH 17 Rev 1/2001

		Please		Black Indelible Ink. Ensu		
		For	State of Maryland	d / Department of Health a	nd Mental Hygien	e 2010 27507
		State     Registrar		Certificate of Death	Reg. N	2010 27507
Physicia Medic		1. Decedent Name (First, Middle, La	ne S	impers	2. Date of Death  Month	Day 14 Year 5:36 am
Examine		4a. Facility Name (if not institution, give	e street and number)	4b. City, Town, or Location of	Death 4	Ic. County of Deaths
Funeral Director		2111011111	Sex 7. Age (In yrs. las	st birthday) If Under 1 Year If Under 2- Months Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day, Year)	9, Birthplace (State or Foreign
aryland a-f show	ector	Usual Residence of Decedent  10a. State  10b. County	10c. City,	Town or Location		10d. Inside City Limits 1 ☐ Res 2 ☐ No
vith the M	by Funeral Director	10e. Street and Number	ah Street	10f. Zip Code 21921	10g. C	Citizen of What Country?
or items	y Fune	11. Marital Status  1 W Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
215-003( lin 72 hours afte e. nan "natural",	eted b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1 ☐ Yes 2 ☑ No Specify:  16a. Decedent's Usual Occupation	16h	Specify: Black Kind of Business Industry
nd 21215-0036 fled within 72 hours after death with the Maryland all Hygliene. 1 other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Be Completed	(Specify only highest gi	rade completed)  College (1-4 or 5+)	(Give kind of work done during most of life DO NOT use retired)	of working	Private Families
	To Be	17. Father's Name (First, Middle, Last)	Simpus	18. Mother	's Name (First, Middle, Maide	e Boulden
Maryl Maryl and Mark		19a mormant's Name/Relationship (	Type, Print)	195. Mailing Address (Street and Number 259 E. H.M.S	or Rural Route Number, City	or Town, State, Zip Code)
Baltimore, bernit. Page 1 and Department of Heal mportant: If item? any injury or other price.		20a. Method of Disposition  1	Removal from State \( \int \) ce	ace of Disposition (Name of metery, crematory or other place)	8 20 2010 NU	Location - City or Town, State
Balti Permit. Departin Imports any injit		21. Signature of Funeral Service Licen	see Com	22. Name and Address of Facility P. D. BOX 2593		LHone De 19805
Physician/		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	nplications that caused the death one cause on each line.	. Do not enter the mode of dying, such as ca	ardiac or respirat Arrest,	Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	a. Oronary  Due to (or as a conseque	ence of):		
ted usit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to for as a conseque	a loe vij:		
O be execu sician and	ical Exa	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):		
8760 tificate ing phy	Medi	IF FEMALE:	- 0			
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medio	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan  1  Live Birth 2 Fetal  4  Pregnant at time of do  9  Unknown	death 3 L Ectopic pregnancy		23d. Date of delivery Month Day Year
IS, P.O.  uires that the signed by a signed by a detact	d by Pr	Part II. Other significant conditions	contributing to death but not resu	lting in the underlying cause given in Part I.		o use contribute to the cause of death?
Division of Vital Records, tal or Attending Physician: The law requires rs after death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be a control or the funeral director.	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
L C L L L L L L L L L L L L L L L L L L	Ö	25. Was case referred to medical		26. Place of Death	1 L Yes 2, X	No 1 Yes 2 No
Vite ysicia s cert direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	Other	sing Home 5 Residence	6 ☐ Other (Specify)
of of ng Phr ng Phr ter thi	te: 1	27. Manner of Death		28b. Time of 28c. Injury at work?	28d. Describe how inju	
ion tendir eath. or: Af	ifica	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	on	M 1 ☐ Yes 2 ☐ N		
Divis ital or At urs after o ral Direct	al Certificate:	4  Homicide determined	building, etc. (Specify)		City or Town, Sta	
the Hosp nin 24 hou the Fune npleted fil	Medical	(Check	niner: On the basis of examination	knowledge, death oncurred at the time, date a	surred at the time, date and pla	ce, and due to the cause(s) and manner stated.
To 1		29b. Signature and title of certifier	<del>}</del>	29c. License number  D0056	3449 29d. I	Date signed (Month, Day, Year)
		30. Name and address of porson who	completed cause of death (Item	23a) (Type, Print) 133N. Bridge	51. 3rd Floo	ElKten MD 2192
Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signatu		2 I	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 27508 Certificate of Death 1. For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3 Time of Death Physician/ Month Day August 24, 2010 0346 hrs Medical Examiner ERIC SINSABAUGH ALAN 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) 17 1987 213-19-2487 22 Oct 1 X M 2 F MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 XNo 28a-f show WV Berkeley Falling Waters I other than "natural", or items 23a or 28a-f shothe Medical Extra must be notified at once, Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8956 Williamsport Pike 25419 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes White 1 Yes 2 X No specify: Specify: 4 Divorced If Yes, Give Year ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Iltimore, MD 21215-0036
ait. Pages I and 2 should be filed within 72 hou
attroent of Health and Mental Hygiene.
ortant: If item 27 is marked other than "nat
ry or other traumatic event, the Medical Ex. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fork Life Operator Construction 12 18.Mother's Name (First, Middle, Maiden Surriame) 17. Father's Name (First, Middle, Last) Be Joseph A. Sinsabaugh Edna P. Sobiech 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna P. Biddle (mother) 1451 Peach Basket Rd. Felton, DE. 19943 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Barratts Chapel Cem. 8/27/10 Frederica, DE. 4 Donation 5 Other Specify 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech 21. Signature of Funeral Service Licen M00510 118 West Cross St. Galena. MI 23a-Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21635 Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /M dical Death Heroin Intoxication Immediete Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical 23a, 27, 28a-f per me g907 9-13-10 vt /sician a burial - t X UNPENDED AMENDED 23d. Date of deliven IF FEMALE: 23c. If yes, outcome of pregnancy phy: 3b. Was decedent pregnant in the past 12 months? attending p 3 Ectopic pregnancy Month Year Live birth Day Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? P.O. contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Division 1 Yes 2 X No Director: d in by the f 5 Pending fd 8-24-10 fd 2:40am unknown Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number City or Town, State) 18613 Horseshoe Bend 3 6 X Could not be Suicide or Town, State) 18613 He Rd, Sharpsburg, determined house Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 25, 2010 O.C.M.E. diela 30. Name and address of person who completed cause of death (Item 23a)

Registrar

Ana Rubio MD.

32. Registrar's Signatur

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010° **Physician** August 06:04 AM Willard Modeana Stephens /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace 8. Date of Birth (Month, Day, Year) March 3,1927 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2√2√F Months Days Hours Min. Kentucky 305-26-9019 83 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location r items 23a or 28a-f shov invermust be notified at 1 ☐ Yes 2√No Director Maryland Ceci1 Rising Sun 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21911 United States 877 Biggs Highway Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No ō Specify: Completed by Specify: Widowed 4 □ Divorced natural" er than "natura", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Al Hygiene. Al Aygiene. Ad other thar c event, ILV Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Brockman Ella Chrisman ည 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 Meadows Grove Road Pine Knot, Kentucky 42635 of Health a David Stephens / Son other t 20b. Place of Disposition (Name of UppeeferyCanatompripher place) Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 21, permit. Pages Department of Important: If it any Injury or c 1 Burial 2 □ Cremation 3 □ Removal from State August Pine Knot, Kentucky 4 ☐ Donation S ☐ Other (Specify) 22. Name and Address of Facility Crouch Funeral Nome 21. Sign flure of Pure Service 127 South Main Street, North East, Maryland21901 23a Part 1. Enter the disea shock, or heart failure Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final **Physician** KUPTURED disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ☑ No 24a. Was an EMENTZ 1 ☐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

W. 11ARD Division of Vital Records, P.O. Box 68760, STEDNENS, Hospital

within 24 hours after death To the Funeral Director: filled in by

29a. Certifier (Check only

Medical

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

501

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 66641

UNION AVE HAVRE de GRACE, MD 21078

State Registrar

completely

the

31. Date filed (Month, Day, Year)

LISA

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KIRKLAND

S.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State of Maryla		artment of H tificate of D		Mental Hy	giene	0 27510	
		Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tilicate of L	eatri	2. Date of De	Reg. No. U	3. Time of Death	
Physic	ian/ dical	Benjamin Omar Sarles				Month Augus	Day Y	ear 10 3:37 P M	
Exam		4a. Facility Name (if not institution, give street and number) Hospice of Queen Anne's		4b. City, Town, or <b>Cen</b>	Location of Death	1	4c. County of	Death Queen Anne's	
Funera Directo		5. Social Security Number 8. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	: last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da NOV • 2	rth ay, Year) 1932	B. Birthplace (State or Foreign Country)  Maryland	
nd how at	٦ ٍ	Usual Residence of Decedent  10a. State 10b. County 10c. 0	City, Town or Lo	cation				10d. Inside City Limits	
Marylar 28a-f s	recto	Maryland Queen Anne's		Church	Hill			1 ☐ Yes 2★No	
with the ss 23a or 2	Funeral Director	10e. Street and Number 1520 Roe Ingleside Road		10f, Zip Code	21623		10g. Citizen of Wh. U.S.A		
iore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	_ ≥	1 Never Married 2XX Married 1 No		Vas Decedent of His f Yes, specify Cubar ☐ Yes 2XXNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. White	
215- n 72 ho e. an "na'	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I	lent's Usual Occupa kind of work done di O NOT use retired)	tion uring most of wor	king	16b. Kind of Busin		
nd 212: illed within " il Hygiene. other than	Be Co	12 17. Father's Name (First, Middle, Last)		Owner			Boaty	ard	
Aaryland should be filed and Mental Hy is marked oth raumatic event	15	Benjamin Redden Sarles			Elea	anor V.	, Maiden Surname) Dodson		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", on any injury or other traumatic event, the Medical Exam		19a. Informant's Name/Relationship (Type, Print) Wendy Gordon/daughter					er, City or Town, Stat ch Hill,		
Baltimore, learnit. Page 1 and Department of Heal Important: If Item 2 any injury or other		NXBurial 2 ☐ Cremation 3 ☐ Removal from State		natory`or other place		Date	20c. Location - Ci		
Baltim permit. Pag Departmen Important: any injury	Ď.	4 Donation 5 Other (Specify)  21. Signature of Funeral Solvice/Licensee		ff Cemete  . Name and Address				, Maryland eral Home	
B P P P	2	I tood E- Kill	/				_	is, MD 21401	
~ Physiciar		Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition      Cirrhosis	s of liv	_	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death Years	
Medica Examine		resulting in death)  Due to (or as a conse  Alcoholis		-				years	
Sit. id	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence of):						
760 cate be executed physician and the burial-transit	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a conse	quence of):						
760 ate be physici the bu	edical	d							
Box 68's death certification attending need for use as	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   23c. If yes, outcome of pregnant at time of the pregnant a	etal death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date o	•	
P.O. that the ned by e detacl	by Ph	Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?	
ords, P.C v requires that s been signed to should be deta	eted !		·			1 🗆		Probably 4 X Unknown	
//tal Reco	Completed						psy prio ormed? dea	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \) No	
ital iician; certific rector,	Be	25. Was case referred to medical examiner?  1 Yes 200000 Hospital:		Other	ce of Death (Chec		-	pice House	
ivision of Vital Rec or Attending Physician. The la after death. Director: After this certificate he i in by the funeral director, page.	ate: To	1 ☐ Inpatient 2 ☐  27. Manner of Death 1 ☐ Inpatient 2 ☐  28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	4		dence 6 🛭 Other (5	Specify)	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23  24  25. Was case referred to medical examiner?  1   Yes   2XXNo   Hospital:  1   Inpatient   2   ER/Outpatient   3   DOA   Other:  27  28  29  20  20  20  20  20  20  20  20  20							Street and Number o vn, State)	r Rural Route Number,	
e Hospitz 124 hours e Funeral	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examinating Nurse Practioner: To the best of	ion and/or invest	igation, in my opinior	, death occurred a	at the time, date a	and place, and due to	the cause(s) and manner stated.	
To th within To th	2	29b. Signature and title of certifier  29c. License number D63747  29d. Date signed (Month, Day, Ye							
		30. Name and address of person who completed cause of death (Ite	m 23a) (Type, P	rint)			-		
1413+1		Jeffrey Ukens, MD 2540 Cent	reville	Road C	entrevi 1	lle, Mar	vland 21	617	
- الماليون	ate	31. Date filed (Month, Day, Year) 32. Pegistrar's Sign	ofuro.					017	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ZU/O 2000 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1433 Baltimore Annapolis Blvd Arnold Anne Arundel 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 16,1933 **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F Months Days Hours Min. 354-26-9515 Ill<u>inois</u> **Director** 77 Yrs. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland Director 10c. City, Town or Location 10d, Inside City Limits MD Anne Arundel Arnold 1 Tes 2 No 10e, Street and Number must be r ò 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with Funeral 1433 Baltimore Annapolis Blvd. 21012 USA ural", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. ed Forces þ 1 X Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1959 1 ☐ Yes 2 XNo Specify: "natural", White Completed 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. the Sales Medical 5+ Be Department of Health and Mental Hy Important: If item 27 is marked oft any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fred M. Sheehan Elizabeth Aughinbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madolin Janie Sheehan/ Wife 1433 Baltimore Annapolis Blvd. Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 16, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Metro Crematory, INC. 2010 Baltimore, MD 21, Signature of Fuer Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Physician/ elonoman V\*10202774 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). -transit and that initiated events resulting in death) Last Due to (or as a consequence of) bunal-1 signed by the attending physician d be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending injury ☐ Accident ☐ Sulcide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical crtifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Praction To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 completed cause of death (Item 23a) (Type Name and address of person

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

AUG 1 7 2010

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Registrar's Signature

32.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Barry Lee Snyder /Medical 8/15/2010 0020 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 M 2 □ F Yrs **Director** 202-32-4370 69 1/5/1941 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is "Actical Evant in a usual be notified at 2008. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No Prince George Upper Marlboro 10e. Street and Number 10f, Zip Code 10q. Citizen of What Country? Funeral 107 Chartsey St. 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Inspector Regional Underwriters 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 Calvin Snyder Blanche Lowry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Snyder Spouse 107 Chartsey St. Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 8/17/2010 Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Seminaticensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration disease or condition resulting in death) Thous /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ fibrillation 1 ☐ Yes 25 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has lirector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 24☐ No 24a. Was an autopsy 2 No 1 ∐ Yes ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1€ npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 16 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 18 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 To the I 29b. Signature and title of certifier 29c. License number D69566 08-15-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michel Medical IVE (1550 2001 Parkway Annopolis, MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 7 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene

1 - State Amend Item 25 per me, g907, 09/01/2010dnb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2<u>010</u> Month Physician/ 9:35 A. Fern Virginia Smith August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F 0770971914 Mary land Director 96 214-10-1070 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No MD Frederick Keymar 10e. Street and Number 10f, Zip Code 10a. Citizen of What Country? "natural", or items 23a or Funeral United States 21757 11433 A. Haughs Church Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced Completed th and Mental Hygiene.

27 is marked other than "nature traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) sewing/tailoring <u>factory worker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic evence. ၉ Jeanette Ida Selby Elmer Eugene Hood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11433 A. Haughs Church Rd., Keymar, MD 21757 John Henry Smith / husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens 08/11/2010 Frederick, MD 22. Name and Address of Facility Reeney & Bastord Funeral Rome 21. Signature of Funeral Service Licensee E. Church St., Frederick, MD 21701 Kre 106 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on ending physician and use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown page 2 should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law After this certificate has autopsy death? Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 22 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manna of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c, Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed Month, Day, Year) ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com Street

DHMH 17 Rev 7/2009

State Registrar

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31. Date filed (Month, Day, Year)

South

555 32. Registrar's Signature MD

Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ David Scheele Month Medical 0425 AM 08 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional Medical Conter **Funeral** Sex 1 M 2 F If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/07/1937 9. Birthplace (State or Foreign 312-36-2691 Director 73 Months Indiána Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director 10c. City, Town or Location ms 23a or 28a-f s must be notified 10d. Inside City Limits Maryland Wicomico Salisbury 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 931 Winding Way 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Army 11. Marital Status the Medical Examiner Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black White etc. 1 ☐ Yes 2 🛣 No Specify: 3 - Widowed 4 X Divorced Army white Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) 5+ Elementary/Seconday (0-12) business owner construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ David J. Scheele Jesse S. Christie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jesse Scheele/mother 32417 Campo Dr., Temecula, CA 92592 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Injury ( 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 8/16/2010 Salisbury, MD Signature of Funeral Service License any Adlioway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. each line. Immediate Cause (Final Interval Between f trysician/ disease or condition resulting in death) Onset and Death Medical ence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated cause). Examine Due to (or as a consequence of) attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 1 Live Birth
4 Pregnant
9 Unknown 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month the detached Day Year Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. The law requires Completed page 2 should 1 Yes 2 No 3 Probably 4 thinknown peen has 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Yes 2 2 🗌 No Hospital or Attending Physician: 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🔲 Yes မ Other: this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After thieted filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work Accident Investigation Could not be 1 ☐ Yes 2 ☐ No Suicide 6 □ 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 only one 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 7/2009

Registrar

30. Name and

31. Date filed (Month Day, Year)

m.D

ddress of person who completed cause of death (Item 23a) (Type, Print)

D34768

100 E Carroll St

2010

Salisbury MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per phys. G907 9/1/10 dk

State of Maryland / Department of Health, and Mental Hygiene
Amend Item 19a per FH G907 9/8/10 dk

Reg. No. 0 | 0 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17 20<sup>Ye</sup>ar PM **Physician** August GUY CURTIS SCARBOROUGH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 800 Southerly Road, Apt. 1407 Towson If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2/20/1923 Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□ F Months Maryland Director 219-18-8783 87 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Example or other traumatic event, It. Medical Example or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 X Yes 2 No Baltimore Directo MD Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21286 800 Southerly Road, Apt. 1407 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: þ White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 5+ Special Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Wilson Guy Whitson Scarborough ပ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)

Katherine S. Scarborough, da

Kathie-Dickson/Daughter 8404 Muldoon Ct., #310, Richmond, VA23228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8/21/2010 Holy Cross Cem. Street, MD 4 Donation 5 Other (Specify) 21. Signature of Poneral Service Licens 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or on shock, or heart failure. List only omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Sydden Immediate Cause (Final **Physician** Cardizac mun correcte disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: NA 13 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 emp Vy 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 s autopsy Pervive emz certificate 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No 2 dire 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death

Director: 6 Could not be determined n 24 hours after deg ne Funeral Directo pletely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 1723829 empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 515 Farmont De Tousen Md 21286

State Registrar

31. Date filed (Month, Day,

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32. Registar's Signature

el

Year)

10

Donna M. Vincenti, MD

30. Name and address of person who completed cause of death (Item 23a)

OCME

29b. Signature and title of certifier

32. Registrar's Signature

Assistant Medical Examiner

State Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 17, 2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 1

		T – For State Registrar	State of M	arylan	d / Depa	artment rtificate	of H	ealth a	and M		giene 0	10	27517
Physici	an	1. Decedent's Name (First, Middle,  DAVID T. WEST(	*							Date of De Month	ath Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution,				4b. City, To	own, or l	Location of	of Death	8	4c Coun	2010 ity of Death	2242
		Memorial	Hospital			E	35	ton	, a outil		40. 00011	Talk	ot
Funeral Director		5. Social Security Number 6 219-32-1524 Usual Residence of Decedent	. N.E	93 (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 12/2/19	th IV. Year) <b>916</b>		place (State or Foreign
yland Now		10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
e Mar Ba-f sh	Director	MD TALBOT	C	E	ASTON								1 <b>X</b> Yes 2□No
with th		10e. Street and Number				10f. Zip C					10g. Citizen o	f What Cour	itry?
ns 23	Funeral	545 CYNWOOD DR	12. Was Decedent I	Ever in U.S	3 13 1		1601		ain? (C-s	aif. Van av Na		red st	
Ind 21215-0036  be filed within 72 hours after death with the Maryland tital Hygiene.  do other than "natural", or items 23a or 28a-f show event, the "scalest Francial" in the natified at	β	1 ☐ Never Married 2 ☐ Married 3 █ Widowed 4 ☐ Divorced	Armed Forces?	No <b>194</b> 3	5 <b>—</b>	f Yes, specify		Specify:	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		ace - Americ ack, White, e ify: <b>WHI</b>	etc.
21215-0036 d within 72 hours aft glene. er than "natural", or , he "edical Frein"	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	grade completed)		16a. Deced (Give life. L	dent's Usual kind of work OO NOT use	Occupat done du retired)	tion Iring most	of workin	g	16b. Kind of I	Business/Ind	dustry
d 21, filed with Hygiene the the the	Com	12	College (1-4or 5	)+)		ET MAI					WOODWO	ORKING	
eve eve	To Be	17. Father's Name (First, Middle, La  THOMAS HECKMAN	WESTON				1			(First, Middle, )RSHEY	Maiden Surna	ime)	
		JON D. WESTON/SO								Route Numbe	er, City or Town	n, State, Zip 20855	Code)
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐ Removal from State	20b. Pla	ace of Dispos	sition (Name natory or othe	of YNAT:		Da		20c. Location	•	
Baltimo permit. Page Department of Important: If any injury or once.	'n	4 ☐ Donation 5 ☐ Other (Specarior Specarior S	cify)		CEMET	ERY		1	1/24	/2010	ARLINGT	ON, V	A
Per mage mage		JOHN 2	MERCER	$G_{r}$	FÉ	LLOWS,	HE	LFENI	SEIN	& NEWN. EASTO	AM FUNE	ERAL H 21601	OME, P.A.
Physician /Medical Examiner  bhysician and the prial-transit	l Examiner	23a. Part 1. Enter the disease, or co shock, or heart failure. List online disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	a conseque	ence of):	so the mode of	of dying,	such as o	cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the last the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the control	2 Fetal o	death 3 🗌	Ectopic preg						ate of delive	ry Day Year
signed	2	Part II. Other significant conditions	contributing to death but	t not result	ing in the un	derlying caus	se given	in Part I.		23e. Did to	bacco use con	tribute to the	e cause of death?
w requir	eted	Deve	<u>ans.</u>		· · · · · · · · · · · · · · · · · · ·					1 □ Ye	es 2 🗆 No	3 ☐ Proba	ably 4 Unknown
ician: The law certificate has ector, page 2 s	Completed	05 Wes early 1								24a. Was a autops perforr	ned?	prior to con death?	sy findings available apletion of cause of
nysician:	0 26	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	»+ 2ПE	R/Outpatient	2 DOA	Othor			Check only on			
ding Phys h. After this funeral di	- 14	27. Manner of Death	28a. Date of Injury (Month, Day,	y 2	8b. Time of Injury		Injury at Work?				ence 6 Oti		)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	1 Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not to determined	on Diese of trive			М	1 ☐ Yes	s 2□N		f. Location (St City or Town	reet and Numb	ber or Rural	Route Number,
To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:		29a. Certifier Certifying P	hysician: To the best of miner: On the basis of and manner state	f mv knowl	edge death	occurred at t	ho timo	date and	place, ar	od alua ta tt		anner as st	ated.
o the lathin 2 the		one) 29b. Signature and title of certifier	and manner state	ed.	and/OF ITVE				occurred				
F 3 F 8		PAA.	m.D.		_	0	cense nu	6 <b>5</b> 6	52	25	9d. Date signe	+ 16	, 2-8/0
S 4+1VA		30. Name and address of person who	Sp, 2191	South	- WZ	int)	سي	Str	cefe	Eas	Con,	PMO	21601
State Registra		31. Date filed (Month Pay Year)	2010 32. Registrar	's Signatur	6 4	- 41							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10c,e,f,19b,perff,G907,9/2/2010,wS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 12 Day Physician/ 2010 ear 12:40P M Florence Winston Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7 Age (In vrs. last hirthday) Funeral <sup>Year)</sup>920 Days Hours 1 M 2 X F New York Director 90 058-14-9341 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. The start; If item 27 is marked other than "natural", or items 23a or 28a-f show lury or orber traumatic event, the Medical Examiner must be notified at. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Finksburg 1 Yes 2 XNo Maryland Carroll Westminst 10f. Zip Code **21048** 10g. Citizen of What Country? 10e Street and Number 2455 Baltimore Blvd, Rm 14 Funeral 21157 United States 2333 Carrollton Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates 16a Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Actress/Drama Coach <u>Classical Acting</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jacob **Ocean** Renner 19a. Informant's Name/Relationship (Type, Print) 1179M#E284dr#M\$1111 agttreet Ruwesteminster, JownBat21497) 2333 Carrollton Road Westminster, Maryland Westminster, Maryland 21157 Wynde Juliet Winston/daughter Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 8/17/2010 Woodbine, Maryland re of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Thomas uanita M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Pelmonary Onset and Death Immediate Cause (Final Physician/ NVONIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this contificate was been been accorded. the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be Vasculas 1 ☐ Yes 2 🖟 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 XNo within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 ID DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D 51705 answiya, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminstel , MD M. PANSURIYA 49 Malcolm

DHMH 17 Rev 7/2009

State Registrar Registrar's Signati

10-06039		Please Type or Print in Bl						jible.		
Archie Willett		State of Maryland		rtment of <i>I</i> tificate of L		id ivientai r		20	010	27519
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last) Archie L. Wille					2. Date of Death Month August 11,		ear	3. Time of Death 2323 hrs
Medical Examin	ier	4a. Facility Name (if not institution, give street and number)				Location of Deat		4c. County	y of Death	2323 1113
		University Hospital  5. Social Security Number 6. Sex 7. Ag	ne (In vrs. Ia	st birthday)	Baltimore  If Under 1 Yea	ar If Under 24Hr	s. 8. Date of Birt	h/MM/DD/YY	(Y) 9 Birth	place (State or
Funeral Director		215-70-1282   1XM 2 F	54	Yrs.	Months Day			/1956	Foreign	
Š.		Usual Residence of Decedent  10a, State 10b, County	10c City	Town or Location						10d. Inside City Limits
1 10 w 8 m	.	MD Howard	_	avage						1 Yes 2 X No
arylanı 8a-f st	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	Vhat Count	ry?
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ath wit	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces	?			spanic Origin?(S n, Mexican, Puert	Specify Yes or No- o Rican, etc.)		ite, etc.	an Indian, Black,
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nours a	ed by	15. Decedent's Education (Specify only highest grade con	,			tion (Give kind of b. DO NOT use re		16b. Kind of E	Business/In	dustry
36 nin 72 l e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 1 2	5+)			penter	ŕ	Cons	truc	tion
5-00 led with	8	17. Father's Name (First, Middle, Last)			Т		e (First, Middle, M			
21215-0036 suld be filed within 7 Mental Hygiene, marked other than event, the Medica	BB	Herbert J. Wi  19a. Informant's Name/Relationship (Type, Print)	.11et		ddross (Stro	Mabel	P.		ross	Zin Codo)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۱٩	Catherine R. Willett/w	rife	8401	Foundr	y St.	Savage	, MD	2076	
ore, I ss 1 and of Healt of Healt of Healt of Healt of Healt of Healt	ĺ	20a. Method of Disposition  1 y Burial 2 Cremation 3 Removal from St.	C	lace of Disposition	nlacel		Date	20c. Location	-	
Baltimore, permit. Pages 1 a Department of He Important: If of He injury or other to		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Ca							red.,MD
Bal Permi Depa Impo injur		Glady 9. Sewell		145	51 Dar	es Bch	ewell r Rd. P	unera rince	Free	me,P.A. d.,MD2067
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death.	Do not enter the	mode of dying,	such as cardiac	or respiratory arre	st, shock, or h	eart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Torso Injuries  Due to (or as a const	equence of	):						Death
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ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach.	و آو						1 Yes	2 🗸 No 3	Proba	bly 4 Unknown
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n of V ding Phy After thi	읽	27. Manner of Death 28a. Date of Inju	Jry I	28b. Time of Inju		ry at Work?	28d. Describe ho	ow injury occu	rred	
Sion ttendir death. ctor: A y the fu	atio	1 Natural 5 Pending Aug 11, 2010 2 ✓ Accident Investigation		2245 hrs		Yes 2 No	Subject fell fr			
Division of Vital Records, Hospital or Attending Physician: The law requir 24 hours after death. Funeral Director: After this certificate has been si	ertification:	Suicide Could not be determined (Specify) Lie	-	me, farm, street, f	factory, office b	ouilding, etc.	28f. Location (St or Town, Sta 195 Northbound	treet and Num ate) 1 & Exit 56 a	oer or Rura t Keith Av	Route Number, City enue, Baltimore , M
ospi hou y fill	ပြု	29a. Certifier 1 Certifying Physician: To the best of m	y knowledge				d due to the cause	(s) and manne	er as stated	l.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.  29b. Signature and title of certifier	mination an	id/or investigation	29c. Licens			no place, and 29d. Date sig		
		MV	\		O.C.I			August 12		., <i></i> uy, roar/
1001 2	ŀ	30. Name and address of person who completed cause of d	,							
drw 3	te	Melissa Brassell, MD Assistant Medical  31. Date filed (Month, Day Year) 32. Registra		9.0		Baltimore, MD	21201			
Registr	ar	31. Date filed (Month, Par Year) 7 2010 32. Registra	w/	9. Span	Kel					
DHMH 17 Rev 1/200	01	OCME		ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 6:20 Barbara Α. Wyatt Medical 4b City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner ruskila If Under 1 Year | if Under 24/Hr Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral** 02 | 09 | 1940 1 □ M 2 😿 F 215-38-0239 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f 1 Yes 2 X No Maryland Salisbury Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ?7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a Funeral 5231 Dove Point Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No 1 Yes 2 X No Specify If Yes Give Specify. Baltimore, Maryland 21215-003 3 ★Widowed 4 ☐ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Family Business Wyatt Wholesale Inc. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mabel Mills Frederick Simpkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dana Malone daughter Department of Health Important: If item 27 6714 Quercus Dr., Hebron, MD 21830 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Parsons Cemetery 08 16 2010 4 Donation 5 Other (Specify) Salisbury, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 conths?
1 Yes 2 No Month for Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 perform 2 No certificate director. 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Yes ER/Outpatient 3 DOA မ Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral Date of injury (Month, Day, Year) 27. Manner of ath 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accider 5 Pending To the Hospital or Attending within 24 hours after death.

7 To the Funeral Director: After completed filled in by the fun Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) istrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 45 Physician/ et Medical 4a. Facility Name (if not institution, give street and number) or Location of Death Baltimore 4c. County of Death **Examiner** IANNOR KOCKROSE 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Haut: If item 27 is marked other than "natural", or items 23a or 28a-1 show any or other traunatic event, the Medical Examiner must be notified at. ury or other traunatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No Ito. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral RockRose Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DISABLE 55AB le Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ OR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troone. MARY 9 Alpharett Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State -71224 CARME -6 4 ☐ Donation 5 ☐ Other (Specify) BALto 22. Name and Address of Facility 21. Signature of Foneral Service Licer SKARC 2829 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ressure 0 9 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for i Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 A Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 8/5 D31464 MD

State

Registrar

StIDALIS A

821 N. EUTAW ST Shite 308 BALTIMORE MD 21261

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 MHZ AH

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month (Ferto)de 5100 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richev Hospice <u>Baltimore</u> If Under 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 M 2 KF Months Days Hours Country) Director 218-36-6400 69 24 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a 3804 Pall Mall 21215 U.S.A. items ; 12. Was Decedent Ever in U.S. "natural", or iten ledical Examiner r 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Black permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) 12th grade College (1-4 or 5+) Laborer Various Jobs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Chetman Evelyn Chetman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monique Taylor-Daughter 3804 Pall Mall Road, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1🛣 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 9/4/2010 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Av Ave, Baltimore, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence oi): burial-transit Due to (or as a consequence of): ending physician use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?

1 Yes 2 No
9 Unknown signed by the at e Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has l autopsy Hospital or Attending Physician: The this certificate 2 □ No Yes 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No ည Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier H006426

State Registrar 31. Date filed (Month, Day, Year) SEP 0 2 2010

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Constint-Brown

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar	State of M	arylar		artmen <i>tificat</i> e			and N	/lental Hy		2 H L		27523
ı	DI	,	Decedent's Name (First, Middle, L.)	.ast)			incat		Catri		2. Date of De		,	<del>-</del>	3. Time of Death
-	Physicia Medic	al	William Joseph								Month	2	8 22°	ear (O	19 17 pm
	Examin	er	4a. Facility Name (if not institution, g FRANKLIN SQUA	·	Tn (		4b. City,	Town, or t		of Death		40	. County of		44 - 4
	Funeral	М		Sex 7. Ag		last birthday)	If Under	1 Year	If Under	24 Hrs.	9 Date of Bin	th		9. Birth	lace (State or Foreign
F	Director		219-44-5425	1 🔀 M 2 🗆 F	64	Yrs.	Months	Days	Hours	Min.	(Month, Da Mar. 3	y, Year)	946	Caun	lifornia
	land show dat	ō	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Loc	ation		-					1	0d. Inside City Limits
	Maryla 28a-f otifiec	irect	Maryland Balti	more	Whi	te Mar	sh								1 ☐ Yes 2 🛣 No
	th the	<b>Funeral Director</b>	10e. Street and Number			_	10f. Zip					10g. Ci	tizen of Wha	at Coun	try?
	ath wi ems 2 r mus	nue	10928 Red Lion	Road 12. Was Decedent B	ver in 11	S 113 M		.162	nanic Ori	igin? (Sne	cify Yes or No-	US	<del>-</del> -		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	Never Married 2      Married 3 □ Widowed 4 □ Divorced	Armed Forces?		If	Yes, spec	ify Cuban,	, Mexicar	n, Puerto	Rican, etc.)		14. Race - Black, \ Specify:		etc.
5-0	"natu edica	plet	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	ind of won	k done du		t of warki	na	16b. K	ind of Busir		
72	ithin 7 iene. r than the M	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. DO Heavy	NOT use	retired)	Ü			Cc	nstru	cti	on
ğ	filed wal Hyg	Be	17. Father's Name (First, Middle, Las	1)		1				_	e (First, Middle,				
Уlа	uld be I Ment narker	2	Archer Andrew A			<del></del>			Lou	ise	Josephi	ne M	lagnes	s	
Σa	2 sho Ith and 27 is r traum		19a. Informant's Name/Relationship Frances Midwig	,							Route Numbe				
Je,	1 and of Hea item		20a. Method of Disposition			Place of Dispos	ition (Nam	e of			Baltim Date		cation - Cit		
<u>E</u>	Page ment tant: If		1 ☐ Burial 2 🔀 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State cify)		emetery, crem .1top_Se	,	, ,	- :	9-1	-10	ТОΨ	son,	Mar	vland
Baltimore,	Depart Depart Import any inj		21. Signature of Funeral Service Lice	nsee							ne, P.A d. Abin		DOLLY		y Idila
Ī		Н	23a. Part 1. Enter the disease, or co	mplications that caused	the deat	h. Do not ente	the mode	okes	oury	Road	d. Abin	gdon	, MD	210	
1	Pnysician/		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line				or aying,	odon do	our undo c	respiratory ar	coi,			Approximate Interval Between Onset and Death
	) Medical Examiner		resulting in death)	a. Falal Due to (or as a										+	
		er	Sequentially list conditions,	b. AThero  Due to (or as a	scl	erot	16 (	2010	nar	1 a	rtery	di	50054	2	
	rted J nnsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	c. Diabet		ience or):									
	ian and	Ë	that initiated events resulting in death) Last	Due to (or as a		ience of):					·				
9	icate be executed physician and s the burial-transit	ledical	•	d											
FEMALE:  23c. If yes, outcome of pregnancy													23d. Date o Month		'Y Day Year
7. Ö	hat the ed by detack		Part II. Other significant conditions	contributing to death bu	it not res	ulting in the un	derlying ca	ause giver	in Part I		23e. Did to	bacco u	se contribut	te to the	e cause of death?
- 'S	luires t	ed by									1 🗆 \	/es 2[	□No 3 □	☐ Prob	ably 4 Unknown
200	aw req as bee 2 shor	Completed	<u> </u>								24a. Was a		24b. Were	autop:	sy findings available apletion of cause of
Ŭ	: The l	5										med?	deat	h?	No
Vital Records,	sician certifi irector	<b>∞</b>	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:				Othor		h (Check					
6	27. Manner of Death  1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other  28a. Date of injury 28b. Time of 28c. Injury							c. Injury at			ne 5 Resid			pecify)	
27. Manner of Death    27. Manner of Death   28a. Date of injury   28b. Time of injury							No								
N/S			4 Homicide determined	building, etc.	(Specify)						8f. Location (St City or Town	n, State)			
	e Hos 24 ho e Fune	Medical	(Uneck 2 L Medical Exam	ysician: To the best of n niner: On the basis of ex	amination	and/or investig	ration, in m	v opinion	death oc	curred at t	he time date an	nd nlace	and due to t	the cause	e(e) and manner stated
only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 29b. Signature and title of certifier 29b. Signature and title of certifier 29d. Date signed (Month.)															
			· /Cl	1/1/1	7		1	25	44	28		8	/30	//	10
_		- 1	30. Name and address of person who								2 0	سد ر	1		- 2 -
	State	9	B1. Date filed SEP. 0 2 2010	32. Registrar	's Signati	ire park	TILL CI	n Sc	الدد	rel	R Ba	40	md	21.	2 > 7
	Registra		OLI UN LOID	1	1	11									

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			1 - For State of Maryland / Department	artment of Health and rtificate of Death		iene2 0 1 0	27524
	Physicia		Decedent's Name (First, Middle, Last)  Margaret Ruth Ande	rson	2. Date of Death Month August	Day Year 31, 2010	3. Time of Death 8:15 A M
	Medic Examin		710 Montgomery Street	4b. City, Town, or Location of Deat  Laurel		4c. County of Deat	h
2	Funeral Director		5. Social Security Number  213-22-1673  G. Sex  1 M 2 XF  Reg (In yrs. last birthday)  Yrs.  Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		Year) 9. Biri Co. 1924 Mai	thplace (State or Foreign unity) ryland
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director		cation	1	0g. Citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ath with t ems 23a r must be	uneral	710 Montgomery Street  11. Marital Status 12. Was Decedent Ever in U.S. 13. V	20707  Was Decedent of Hispanic Origin? (S		U.S.A.	
0036	urs after de: :ural", or ite			f Yes, specify Cuban, Mexican, Puert	to Rican, etc.)	14. Race - Ame Black, White Specify: Who	e, etc.
Maryland 21215-0036	vithin 72 ho jiene. <b>er than "na</b> l <b>the Medic</b> s	Completed by		dent's Usual Occupation kind of work done during most of wo O NOT use retired) . <b>tor</b>	rking	16b. Kind of Business Real Esta	
yland	ild be filed v Mental Hyg larked other atic event,	To Be	17. Father's Name (First, Middle, Last) Roland L. Nichols, Sr.		me (First, Middle, M Powers	aiden Surname)	
e, Mar	and 2 shou lealth and em 27 is m ther traum		Michael S. Anderson /son 6015	ng Address (Street and Number or Ru Brooklyn Bridge	Rd., Lau	rel, Maryl	and 20707
Baltimore,	it. Page 1 rtment of I rtant: If ite njury or of		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary	natory or other place) 's Cemetery Sept	4, 10		ryland
Вa	perm Depa Impo any ii	82 3	21. Sign full. Funeral service Lic nate M00773 3  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter	Name and Address of Facility Onaldson Funeral 13 Talbott Ave.			707-4389
	nysician, ) Medical Examiner	-	shock, of bear value. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Aortic Valve Dis Due to (or as a consequence of):  Sequentially list conditions,  b.	ease	or respiratory arres	я,	Approximate Interval Between Onset and Death
), ),	ate be executed bhysician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Atrial Fibrillat  Due to (or as a consequence of):  Anaemia	ion			
. DOX 00/1	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
1S, P.O.	uires that th n signed by uld be deta	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the understand Heart Failure	nderlying cause given in Part I.		acco use contribute to	the cause of death?
Vital Records,	. The law req cate has bee page 2 shor				24a. Was an autopsy perform	prior to o led? death?	copsy findings available completion of cause of
iii oi vitai	nding Physician th. : After this certifi : funeral director	To B	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year)  28b. Time of injury	26. Place of Death (Che. t 3  DOA Other: 4 Nursing H 28c. Injury at work? M 1 Yes 2 No		nce 6 Other (Speci	fy)
DIVISION OF	tal or Atter is after dea al Director led in by the	al Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	o the Hospi rithin 24 hou o the Funer ompleted fill	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, death of the body of the bo	gation, in my opinion, death occurred.	at the time, date and ace, and due to the c	place, and due to the c ause(s) and manner as	ause(s) and manner stated. stated.
	F 3 ¥ ŏ				29	d. Date signed (Month $9 - 1 - 3c$	) (10
	\2 Stat	е	30. Name and address of person who completed cause of death (Item 23a) (Type, Pi M·H. CHAUDHPY, M.D. 7610 CARROL 31. Date filed (Month, Day, Year)  SEP 0 2 2010  32. Registrar's Signature	LAVE. Tak	OMA, PA	RK, MAR	YLAND 2098
	Registra	r	SEP 0 2 2010 Depend B. Aga	Cres			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me,2907,09/02/2010dhb

Reg. No.

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AVGUST Year **Physician** 2-10 PM lista rene Haums 20 2016 /Medical b. City, Town, or Location of Death 4c. County of Deatl 4a. Facility Name (If not institution, give street and number) Examiner Nursing Howard If Under 1 Year | If Under 24 Hrs. ial Security Number 6. Sek Age (In yrs **Funeral** Days 1□M 2XF Director Usual Residence of Decedent death with the Maryland 10c. City Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Kaltimore 1 Yes 2 No M Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Kenilworth Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) illiam PLANS Hora ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9764 (71v0CVII)()00 DriVE EllicoHCity, Md. 21042 Informant's Name/Relationship (Type. Print) 20b. Place of Disposition competery crematory 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatur / f Funeral Servi e Lice see 22. Name and Address of Facility Vaughn NO15 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE ysician TO THRIVE FEW DAYS /Medical Due to (or as a consequence of): Examiner DEMENTIA FEW YRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTER ATTOM MERCINED BY MEDICAL EXAMINER Due to for es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by CERVICAL SPIKE FRACTURE 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 A Yes - 2 Nofuneral director, 26. Place of Death (Check only one) Other: 42 Nursing Hame 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? July 5, 2010 2:00 A M 5 ☐ Pending investigation 1 ☐ Yes 2 XNo Subject fell. 2 X Accident 3 ☐ Suicide 24 hours after death Funeral Director: 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, 716t, Fairbrook Road Windsor Mill, Maryland 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Assisted Living Facility 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 AU SIUST 20,2010 MO 0062634 30. Name and address or person who completed cause of death (Item 23a) (Type, Print)

MATEGO AWA 10796 HIC

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State Registrar 31. Date filed (Month, Day, Year)

SEP 0 2 2010

HICKORY RIDGE RD 10796 Registrar's Signature

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21-44

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ugust Anita Brown Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner 4c. County of Death General If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 ⋤ F 216-76-5730 Director 52 Yrs 8-19-1958 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notified at 10a. State 10b. County items 23a or 28a-f shoner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 - Yes 2xxNo MD Pasadena Anne Arunde 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 185 Mountain Road 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item ledical Examiner <u>n</u> 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify, If Yes, Give Year or Dates Black Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BELLO MACHRE FAMILY LIVING ASSITANT 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leroy Brown Nelly Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nellie R. Brown-Mother 185 Mountain Road Pasadena, MD 21122 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 9-7-2010 Glen Burnie, MD Glen Haven Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H E Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner 1ator reumonia if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Tes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural inlury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier 1 🖳 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number

State Registrar Robina Rana. MD.

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

0

30/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year рм Freddie Brown 2010 9:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balto Timonium Stella Maris Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1XXM 2 □ F Months Hours Min (Month, Day, Year) 219-22-0395 Director 82 3-27-1928 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f st e notified 1 U Yes 2 XX Timonium Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a on any injury or other traumatic event, the Madical Examiner must be. Completed by Funeral Valley 21093 USA Dulaney 2300 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Yes 2 No Never Married 2 Married 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates Decedent's Education. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Goetze Candy Co. Elementary/Seconday (0-12) College (1-4 or 5+) <u>Laborer</u> 10th grade Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ellenor Grant Basil Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 1503 N. Kenwood Avenue Balto, MD Mamie B. Johnson-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Memorial Pk 9-8-2010 Randallstown, 4 Donation 5 Other (Specify) Signature of Funeral Service License March East F/H MD 21202 1101 Ε. North Avenue Balto, 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician END STAGE KIDNEY DISEASE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, signed by the attending physician and defected for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 🗌 Probably 4 🗍 Unknown been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsv perform death? 1 ☐ Yes 2 🗶 No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide within 24 hours after death To the Funeral Director: Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Contifying Nurse Fractioner: To the best of my knowledge, death becum 29b. Signature and title of cert 29d. Date gigned (Month, Day, Year) 2010 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES **CRNP** 2300 DULANEX VALLEY RD. TIMONIUM, MD 21093

Registrar

DHMH 17 Rev 7/2009

State

AUGUST

FREDDIE BROWN

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of M	arylan			it of Healt e <i>of Deat</i>		Mental Hy	•	2010	27528	
			Registrar  1. Decedent's Name (First, Middle	, Last)			0.2041		2. Date of De			3. Time of Death		
	Physicia Medio		TEDDY FI	RANCIS B	URKE					Month AUGUST	Day 31	Year 2010	7:16A M	
-	Examin	er	4a. Facility Name (if not institution, FREDERICK MI	-	TENT		, ,	Town, or Locati	ion of Death		1	County of Dea		
	Funeral		5. Social Security Number	6. Sex 7. Ag		ast birthday)	If Unde		nder 24 Hrs.	8. Date of Bir	th	EDERICI 9. Bir	thplace (State or Foreign	
	Director		577-58-5094	1 🕅 M 2 🗆 F	67	Yrs.	Months	Days Hou	rs Min.	June 26	, Year) 4	$3  V_{1}^{c}$	rginia	
	nd how		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits	
	Maryla 8a-f s tiffied	Director	Maryland Fred	lerick		Brunsv	vick						1 ☐ Yes 2 🔀 No	
	h the la or 2		10e. Street and Number		000		10f. Zip				-	zen of What Co	-	
	ath wit	Funeral	1100 Peach Orch	ard Lane Apt			Nas Dece	21716	Origin? (Sp	ecify Yes or No-		ed Stat		
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	and 2 s Health em 27 ther tr		Terry Burke, Br	other	Took 5				, Mt.	Airy, N				
Baltimore,	0 = =		1 ☐ Burial 2 🎛 Cremation 4 ☐ Donation 5 ☐ Other (S		С	Place of Dispo emetery, cren	natory or c	ther place)	00 /01	Date		cation - City or		
altir	permit. Page Department Important: I any injury o once,		21. Signature of Funeral Service L			ro Cren							Maryland ryland, Inc.	
<u>~</u>	P E E	- 2	Smana.	ederick	Road	, Baltin	nore,		and 21228					
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0 10	nding I Ith. After funer	cate	27. Manner of Death 1 Actural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 1 Accident Investigation 28b. Time of injury at work? 1 Yes 2 No								occurred			
Division of Vital Records,	r Atter ter dea rector by the	ertifi	27. Martiner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28a. Date of injury 28b. Imme of injury work? 1 Yes 2 No  28b. Imme of injury at work? 1 Yes 2 No  28c. Place of Injury - At home, farm, street, factory, office City or Town, State)								ural Route Number,			
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								cause(s) and manner stated.				
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		mb 35106 8/31/2010							7010					
			30. Name and address of person  Muuna Hee			7 23a) (Type, F		Frodo	rick	mpa	170			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra					, , , , , ,		( )			
	Registr	ar	SEP 0 2 2010	1 Buch	1	Marko	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cert	tificate c	f Death		7.0	Reg. No.	110 2152
Physicia Modical Exami		Decedent's Name (First, Middle					-	2. Date of D Month	eath	3. Time of Death 1230 hrs
Medical Exami	ner	4a. Facility Name (if not institutio		Mark	Blum	4b. City, Town, o	or Location o		30, 2010 Yea	
		4200 Primrose Avenu	-	,		Baltimore	or Levanor.		70. Godniy	N/A
Funeral		5. Social Security Number Unic	-6. Sex 7. A	Age (In yrs. la	st birthday)	If Under 1 Ye			Birth (MM/DD/YYY)	9. Birthplace (State or Egraige)
Director		218-64-5421	1 <b>X</b> M 2_F		57 Yr	Months Da	ays Hours	Min. FEB	14, 1953	Foreign CountryMaryland
any		Usual Residence of Decedent  10a. State 10b. County		10c City 1	Town or Loca	tion				10d. Inside City Limits
		, ,	altimore		onsvi					1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number		<u> </u>		10f. Zip Code			10g. Citizen of Wi	
5-0036 ed within 72 hours after death with the Maryland Iygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Ö	25 S. Prospec	t Avenue				21228		US	SA
h with	Funeral	11. Marital Status	12. Was Deceder					in? ( Specify Yes or Puerto Rican, etc.)	No- 14. Race	- American Indian, Black, e, etc.
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5-0036 led within 72 hours at tygiene. other than "natural the Medical Examin	ompleted	Elementary/Secondary (0-12)				nost of working life			Tob. Nana or Ba	ion loos industry
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MD 2 d 2 shou Ith and I n 27 is r	۲	Brooke E. Blum		r		E. Cler				
	Ì	20a. Method of Disposition		20b. PI	ace of Disposematory or of	sition (Name of ce	emetery,	Date		E. MD 21230 City or Town, State
Baltimore, permit Pages I an Department of He Important: If ite	1	1 Burial 2 X Cremation 4 Donation 5 Other Sp		Met		ematory,	Inc.	09/01/10	Baltin	more. MD
Baltimo permit Page Department of Important: injury or ott	ļ	21. Signature of Funeral Service	Licensee George	MacNa	bb 22.1	Name and Addres				of MD, Inc.
	_	Seon 1	TANK	at the end and the F		99 Frede		Road B	Altimore,	MD 21228
Physician Wedical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.						rrest, shock, or hea	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con:		tnadoi	ne Intox	icatio	on		Deau
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760, icate be physical the buril		IF FEMALE:	23c. If yes, outco	rFH,G90 ome of pregna					23d. Date of	delivery
Sox 687 leath certific e attending   for use as t		23b. Was decedent pregnant in the past 12 months?	Description of the control of the co	at time of deat	_ = =		Ectopic	pregnancy	Month	Day Year
Box 68 e death certification the attending ed for use as	Physician	1 Yes 2 No 9 Unk	nown 9 Unknown	at time of deat	n 5 01	her (Specify)				***
O. B. interest depth		Part II. Other significant condition	ons contributing to dea	th but not res	ulting in the u	ınderlying cause	given in Par	rt I. 23e. Did	tobacco use contri	bute to the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	ğ D						_	lY	es 2 <b>√</b> No 3[	Probably 4 Unknown
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ViSi or Att fter de Directe	ertification:	2 Accident Invest 3 Suicide 6 X Could	tigation 28e Place of I			et, factory, office t	building, etc	28f. Location	(Street and Numbe	er or Rural Route Number, City
Divi	$\alpha$	4 Homicide determ		found	in hot	el room		4200 H		Ave. Balto, Md.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	<u>ē</u>	10110011011	nysician: To the best of miner: On the basis of exa							
To To Com	Med	29b. Signature and title of certifier	and manner stated		011	29c. Licens				ed (Month, Day, Year)
		6) (A)	the Hon	16/2	000	O.C.	M.E.		August 31,	2010
d	-	30. Name and address of person v	who completed cause of	death (Item 2					٠	
Ť		Victor Weedn MD JD	Assistant Medica			enn Street, E	Baltimore	, MD 21201		
Sta Registi		SEP 0 2 2010	32. Registra	ar's Signature						
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	of Maryla	and / Depa <i>Cer</i>	artment tificate	of He	alth an eath	d Men	ntal Hyg	giene 2	010	27530
			Decedent's Nam	ne (First, Middle							2. [	Date of Dea	th		3. Time of Death
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	Examin		4a. Facility Name (i.	f not institution,	give street and nun	nber)		4b. City, To			eath		4c. C	ounty of Death	
	1		Encore A 5. Social Security N		Valley As			Marri		ville f Under 24 F	Uro O F	D-1 ( D) 11		roll	
	Funeral Director		214-20-05		1 ☐ M 2 <b>X</b> F	7. Age (in yrs	84 Yrs.					Date of Birth Month, Day DV • 22		Indi	hplace (State or Foreign Intry) ana
			Usual Residence o	т-									.,	, , , , , ,	
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	e Mar r 28a	)ire	10e. Street and Nu			на	lethorp	10f. Zip C							1 Yes 2 No
	vith th	<b>Funeral Director</b>	5819 Hero		۵			2122				1	_	n of What Cod l State	-
	eath v	-une	11. Marital Status	DI DI IV	12. Was Dece			Vas Deceden	t of Hispa	anic Origin?	(Specify )	Yes or No-		Race - Amer	
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3	ours a tural' al Exa	Completed	3 XWidowed		If Yes, Giv Year or Da	ates.		☐ Yes 2							White
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9500-61212	within jiene. er tha the h		Elementary/Sec N/A	onday (0-12)	N/A <sup>College (1</sup>	-4 or 5+)	Secre		in CC)				Cler	ical	
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Na	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's N Larry		nip (Type, Print) ett/ Son		11	-					-	wn, State, Zip	· ·
ย์	and Healt tem 2		20a. Method of Dis			20b	. Place of Dispo			ine, (	Date	svill		yland tion - City or	
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baltimore,	permit. F Departm Importa any injui once,		21 gnature of F			1 1	22	. Name and A	Address o	of Facility A	MBROS	SE FUN	VERAL	HOME,	INC.
۵		Ä	Talu	ia a	un Dan	hate	13	28 Sul	phur	Spri	ng RI	)., A1	butu	s,Mary	land 21227
	4.				complications that only one cause on ea		eath. Do not ente	r the mode o	of dying, s	such as card	diac or res	piratory arre	est,		Approximate Interval Between
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	Medical Examiner		resulting in death)	- 1	Due to	or as a conse	equence of):								
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	uted Id ansit	ami	cause. Enter Under Cause (Disease or that initiated event	rlying iinjury	c. ———										
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00	ding p	× W	IF FEMALE:		23c. If ves, out	come of prea	nancv						00		
Š	ath c atten I for us	Physician/Me	23b. Was decedent in the past 12 1 \( Yes \) 2 [	months?		Birth 2 🗆 Fo	nancy etal death 3 of death 5	Ectopic pred Other (spec	gnancy ify)				230	d. Date of deli Month	very Day Year
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	s that gned be se det	þ	Part II. Other signi	ficant conditio	ns contributing to d	eath but not r	esulting in the u	nderlying cau	ise given	in Part I.				contribute to	the cause of death?
<u>ה</u>	equires	ted										1 🗆 Y	es 2 🕡	No 3□Pr	obably 4 🗆 Unknown
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<u>.</u>	siciar certif irecto	o Be	25. Was case referr examiner?  1 \sum Yes 2 \big[	No Medical	Hospital:		75000		Other	of Death (C					
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ה א	or Atter de frer de irrecte	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6  Could r determi	ined 28e. Place	of Injury - At	home, farm, stre	et, factory, of	ffice			Location (St City or Town		umber or Run	al Route Number,
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:	e Hos 124 ho e Fun eleted	Medical	(Check 2	🖳 Medical E	Physician: To the b xaminer: On the bas Nurse Practioner:	is of examinat	ion and/or invest	igation, in my	opinion, o	death occurr	red at the ti	ime, date an	d place, an	d due to the c	ause(s) and manner stated.
:	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours fact death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	2	29b. Signature and		ranso i ractioner.	,0 110 2001 01	, monloage, c		icense nu		- piace, all			igned (Month,	
			1 /n	when	Den	r 1	MD		D	5100	51		Sent	tembe	r1,2010
			30. Name and addr	ess of person v	vho completed caus	e of death (Ite	em 23a) (Type, P	rint)	0		1.15	11-	1		, = , 0
			A No. 31. Date filed (Mont	h. Day Year	alazar	egistrar's Sigr		GON	Rd	1 21	llice	TTL	17/	MD	21042
	Stat Registra		SEP 0 2		General		barre								

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Samantha Butche		State of Maryland / Department of Health and Mental Hy  1-For State  Certificate of Death	ygiene	2010	27531
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Deat		3. Time of Death
Medical Examin	er	Samantha N. Butcher  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	Month August 31	Day Year , 2010 4c. County of Death	1134 hrs
		4522 Umitilla Avenue Baltimore		NIA	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.  22   58 458   1 M 2 F 35 Yrs.	8. Date of Birt	th (MM/DD/YYYY) 9. Bir Foreig	thplace (State or gn untry)
	4	Usual Residence of Decedent	VMAY D	18, 1975 °°	untry)
d tow any		10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits  1 Yes 2 No
4arylan 28a-f sh Lat onc	Director	MD N/B Boltimore  10e. Street and Number 10f. Zip Code	10	ng. Citizen of What Cou	
th the A		4522 Umitilla Ave. 21215		USA_	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Specific Cuban, Mexican, Puerto Full Press, Specify Cuban, Mexican, Puerto Full Press, Specify Cuban, Mexican, Puerto Full Press, Specify Cuban, Mexican, Puerto Full Press, Specific Cuban, Puerto Full Press, Spe		- 14. Race - Ameri White, etc.	can Indian, Black,
s after d		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: BIG	rck
72 hour n "natu al Exan	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of we during most of working life. DO NOT use retired to the during most of working life.		16b. Kind of Business/I	•
within giene.	dwo-	10th Cashier		Restaur	ant
D 21215-0036 should be filed within 72 hours after death with the Maryland and Montal Hygiener is a fire to be filed within 72 hours after death with the Maryland is marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once	S P	17 Father's Name (First, Middle, Last)  18. Mother's Name (Elizabe)  Elizabe		utcher	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mannell Hygiens. Department of Health and Mannell Hygiens. The is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	9	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Relationship)  19c. Mailing Address (Street and Number or Relationship)  19c. Mailing Address (Street and Number or Relationship)	n 10 1	ber, City or Town, State	-
Baltimore, MI Permit. Pages I and 2 s Department of Health at Important: If item 27 njury or other traum.	F	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
Baltimore, permit Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specific Metro Crematory 9/2	110	Catonsvill	e, mo
Balti permit. Departm Imports		21. Signature of Funeral Service Licensee  A Name and Add s of Facility  AND FOOTB I HO	eral H	ome P.A. 2	1229
Physician /M	1	23a. Part Let life disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	W 47.1		Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Steatosis and Cirrhosis of the Live  Due to (or as a consequence of):	r		Death
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
		Course. Enter Underlying Course (Disease or injury that initiated c			
cuted and transit	֡֟֝֟֟֟֟֟֟֟֝֟֡֟֓֓֓֓֓֟֟	events resulting in death) Last Due to (or as a consequence of):  d.			
O, e be executed /sician and burial - transit	υ <b>–</b>	■ UNPENDED □ AMENDED 23a,pt.II,27 per me g908 10-I	9-10 vt		
6876 ertificate ding phy		IF FEMALE:  3b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy	су	23d. Date of delivery Month D	ay Year
BOX death or attended for use	ysic	1  Yes 2 No 9 ✓ Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
res that the death certificate signed by the attending physic be detached for use as the b	ב ה	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Pancreatic Cancer		pacco use contribute to t	
ds, Frequires	מופח	Tancieatic Gancei	24a. Was ar		opsy findings available
Vital Records, sysician: The law required his certificate has been; director, page 2 should	paladillo		autops perform 1 ✓ Yes 2	ned? death?	ompletion of cause of
ician: Ticertifica		25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing		10 10	2 140
n of Vi ding Physi I. After this funeral dir	2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2		Residence 6  Other:	Scene
ttendin Heath. Hor: Al		1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No			
Division of Vital Records, P.O. Box 6876 spital or Attending Physician: The law requires that the death certificate nours after death.  neral Director: After this certificate has been signed by the attending phy filled in by the funeral director, page 2 should be detached for use as the treatment of the contribution of the contribution.		3 Suicide 6 Could not be determined	8f. Location (Str or Town, Sta	reet and Number or Run ate)	al Route Number, City
ospi hou y fill		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and di	ue to the cause	(s) and manner as state	d
To the How within 24 h To the Fun completely	שבתור ביותר	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tand manner stated.  29b. Signature and title of certifier 29c. License number		nd place, and due to the 29d. Date signed (Moni	
		O.C.M.E.		September 1, 201	
	3	30. Name and address of person who completed cause of death (Item 23a)  Doppe M. Vincenti, MD. Assistant Medical Examiner 111 Pope Street Baltimore MD			
Stat	<b>e</b> 3	Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature	21201		
Registra		SEP 0 2 2010 Denne B. March			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27532 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 30, 2010 MARJORY LEE BARROW 4:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hart Heritage Street Harford | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | Sep. 20 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Maryland Year 1918 1 □ M 2 🕱 F Director 91 Sep. 220-05-2988 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Maction Exercise. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2626 Thomas Run Road 21015 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Nidowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 School Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martha Susan Holland Jacob Roy Enfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fay E. Barrow / Son 2316 W. Medical Hall Rd., Bel Air, MD 21015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Creek U.M.C. Cem 9-3-10 Forest Hill, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STASK Physician END disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Assisted ၉ 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funer Living 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

SEP 0 2 2010 Registrar

29b. Signature and title of

31. Date filed (Month, Day, Year)

certifie

32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALFRAD SPANKS 615 Wast Michigan Bel Ain MD. 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND of Mary and Berarment of Hearth and Wental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Cicero H. Brown, Jr. 2010 10:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 21286 1008 Hart Road Towson. Marvland Baltimore 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 Ø M 2 □ F Months Davs Hours Min. 06-22-1923 578-20-4064 Director 87 Highpoint, NC Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If them 27 is and Mertal Hygiene. Important: If them 27 is and death of the ritan "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Towson, MD 21286 1008 Hart Road 21286 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3X Widowed 4 ☐ Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Architect <u>Self Employeed</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Cicero H. Brown, Sr. Lala Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 Hart Road Nancy Katherine Brown Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 8/30/2010 Baltimore 21. Sature of Funeral Service Licensee 22. Name and Address of Facility Lassahns Funeral Homes Me 7401 Belair Road Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Continued Fractions | Fract 29a. Certifier (Check enheren 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) D44560 120 SISTER PIERRE DR sslof person who completed cause of death (Item 23a) (Type, Print) 5. JEFFROY EXASOLA NO PA TOWSON MAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

SEP 0 2 2010

rack

10-06571 Danielle Batze

0-06571		Please Type or Print in Black Indelible Ink. Ensure All Cop		2010 gible.	27534
anielle Batze		State of Maryland / Department of Health and Mental 1-For State  Certificate of Death			
Physici	ian/	Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Deatl		3. Time of Death
ledical Exam	iner	Danielle II. Date	Month August 31		1557 hrs
		4a. Facility Name (if not institution, give street and number)  Baltimore Washington Medical Center  4b. City, Town, or Location of Dea	ath	4c. County of Deat Anne Arunde	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H		h (MM/DD/YYYY) 9. Bii Forei	
Director		214-15-0697 1 M 2XF 23 Yrs.	in. 04/28		ountry) MD
any		Usual Residence of Decedent  10a. State			10d. Inside City Limits
	<u>ا</u>	Maryland Baltimore Baltimore			1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
ith the 23a or	al Di	2704 Daisy Avenue 21227  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (	Specify Ves or No-	USA	ican Indian, 8lack,
leath w	uneral	1 X Never Married 2 Married 1 Yes 2 X No		White, etc.	real mulan, black,
after d	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:			nite
hours "natur	ted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use relative to the property of the proper	of work done etired)	16b. Kind of Business/	Industry
336 thin 72 ne. than edical	ompleted	12 Never Worked		N/	A
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	S	17. Father's Name (First, Middle, Last)  18.Mother's Name	me (First, Middle, M	aiden Surname)	
212° ould be i Mental marke ic event	o Be	James M. Wolfe Doree  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number o			, Zip Code)
MD d 2 sho lth and n 27 is	-	Doreen Batz (mother) 2704 Daisy Avenue,	Baltimore	, MD 21227	
re, leal of Heal		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  See See See See See See See See See Se	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: Loudon Park Cemetery	2010	Baltimore	
Ball permit Depar Impos		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3111 Mountain F			Home, P.A.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause or each tine.			Approximate Interval Between Onset and
/M i I Examiner		Immediate Cause (Final disease a. Combined Methadone and Alorazolam	Intoxicat	ion	Death
. '		or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
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	ledic	X UNPENDED #23a,27,28a-f,perME,G908,10/1/	/2010,WS	23d. Date of deliver	
Division of Vital Records, P.O. Box 68760, within 24 hospital or attending Physician: The law requires that the death certificate be exwithin 24 hours after death. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical	23b. Was decedent pregnant in the a limit Live birth 2 Fetal death 3 Ectopic pregr	nancy		Day Year
SOX (leath ce attender for use	ysici	1 Yes 2 No 9 ✓ Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
s, P.O. Boires that the designed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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Hospit 24 hour Funer: tely fill	al Ce	4 Homicide 199a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only		rpe, Maryla (s) and manner as state	
Division of ' within 24 hours alter death To the Funcial or Attending Ph within 24 hours alter death To the Funeral Director: After t completely filled in by the funeral	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
1	Ž	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (Moi	
*		30. Name and address of person who completed cause of death (Item 23a)		September 1, 20	10
		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis	uar	SET UA CUIU POPULATION			

OCME

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State of Maryland / Department of Health and Mental Hygiens

Physician   Modical Examiner   Act Plants   Body   Physician				1- State of Maryl State of Maryl Registrar		rtment of H			71111	27535
School   S				1. Decedent's Name (First, Middle, Last)	Ω	1		2. Date of Death Month	Day Year	2000 1
Secretary   Secr	1						Location of Death			
Directory		·	Н		vrs last hirthday)			8 Date of Birth	9 Right	Inlane (State or English
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Privician   Modical Examiner		land low			: City, Town or Loc	ation				10d. Inside City Limits
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Privician   Modical Examiner		3a or 3	a Dir	10 Street and Number	# Floor	10f. Zip-Code	121	10g.	Citizen of What Cou	ntry?
Privician   Modical Examiner		items 2	uner	11. Marital Status  12. Was Decedent Ever in Armed Folkes?		Vas Decedent of His Yes, specify Cuban	spanic Origin? (Spec n, Mexican, Puerto R	cify Yes or No- lican, etc.)		
Privician   Modical Examiner	920	al", or	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify: ${f B}$	lacic
199. Informant's Name/Relationship (Type. Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State)   21 a. Superior of State   21 a. Superior of State   21 a. Superior of State   22 a. Superior of State   23 b. Marked of Disposition   24 b. Marked of Disposition   25 b. Marked Disposition	15-0	n 72 hc i "natur edical	oletec	(Specify only highest grade completed)	(Give k	and of work done di	ition uring most of working	16b	. Kind of Business/li	ndustry
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Physician / Medical Examiner  Physician / Medical Examiner  Sequentially is conditions as a consequence of):  Sequentially is conditions as a consequence of):  Due to (or as a	<u>m</u>	ë° ± ≥			cemetery, crem	T .C	7/9/	201000	JINUSMi'	Us. MD
Physician Medical Examiner  23a. Part 1. Entify the diffesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Due to (or as a consequence of):  Sequentially list conditions, line and the part 1. Due to (or as a consequence of):  Sequentially list conditions, line and the part 1. Due to (or as a consequence of):  23d. Date of delivery Month Day Year of the part 1. Description of cause of death?  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use pontribute to the cause of death?  1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy prior to completion of cause of death?  25b. Was case referred to medical examiner?  25c. Was case referred to medical examiner?  25d. Was case referred to medical e	Balt	permit. Departr Importa any Inj once.		21. Signature of Funeral Service Licensee	z ) ½	Jame and Iddre	Cacility	ene Fu	weral	Services
Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or conditions resulting in death)   Immediate Cause (Final disease or cause of death resulting in death)   Immediate Cause (Final disease or cause of death resulting in death)   Immediate Cause (Final disease or cause of death resulting in death)   Immediate Cause (Final disease or ca				23a. Part 1. Enter the disease, or complications that caused the d	leath. Do not ente	r the mode of dying	, such as cardiac o		10/4L	Approximate Interval Between
Sequentially list conditions, cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Populose of the part o	ŧ.			Immediate Cause (Final disease or condition settling in doubt)		renal	disease			Onset and Death
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A composition of cause of death?    Composition   Composit	<u></u>	ed sit	niner	Sequentially list conditions, if any law in 1 mm flat cause. Enter Underlying Cause (Disease or injury)	sequence of):					
FFEMALE:   23d. Date of delivery   23d. Date of deli	) Je	execute n and rial-tran		that initiated events C	sequence of):		***			
FFEMALE:   23d. Date of delivery   23d. Date of deli	3760	hysicia	dical	d						
SOLUTION Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   No   3   Probably   4   Unknown  24a. Was an autopsy performed?   1   Yes   2   No   1   Yes   2   No    25b. Was case referred to medical examiner?   1   Yes   2   No    26c. Place of Death (Check only one)  Hospital:   Inpatient   2   ER/Outpatient   3   DOA    Other:   4   Nursing Home   5   Residence   6   Other (Specify)	39 x	n certific nding p use as		23b. Was decedent pregnant 23c. If yes, outcome of pre					23d. Date of deliv	very .
To be a control of the cause of death?    1   Yes   2   No   3   Probably   4   Unknown	Ö.	e death the atte	ysicia	1 Yes 2 No					Month	Day Year
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25. Was case referred to medical examiner?  1   Yes   2   No   1   Yes	Rec	ne law has b ge 2 s	omple					autopsy performed?	prior to c death?	ompletion of cause of
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27. Manyer of Death   28d. Date of Injury	Divi	or Atte after de Directo I in by t	ertific	determined 26e. Flace of Injury - A		et, factory, office	28			ral Route Number,
The state of the s		lospital t hours uneral ely fillec		(check only 2 Medical Examiner: On the basis of exam						
29a. Certifying Physician: fo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)		or the H	Medi	one) and manner stated.						
Bett Toldst RES-000 August 30, 2010		F 5 F 0		Sett Bolds		RES	5-00C	A	agust 3	0,2010
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Set L Golds Tail  600 North Wolfe St, Baltimore, MD, 2128		5		5 is (         )	(Item 23a) (Type, P	Print)	600 N	orth Wolfe	St. Baltimo	re. MD. 21287
State Registrar SEP 0 2 2010  Registrar SEP 0 2 2010  Registrar SEP 0 2 2010				31. Date filed (Month, Day, Year) 2. Registrar's Sig	gnafire for	le s				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Bradley :15 PM Delores /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State (State or Foreign **Funeral** Months Hours Days 212-70-6068 Usual Residence of Decedent 1 □ M 2 □ F Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Maryland Experiment, 181 by Indithed at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1- Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No p If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FACTOR -1/ 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Method of Disposition 1 Burial 2 ☐ Gremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service License Part 1 Uniter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. 23a. Part 1.12 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) natic l+e /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 No 24a. Was an autopsy performed? 1 □ Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Il Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

State

29b. Signature and title of certifier

SEP 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's agnatur

Registrar

29c. License number 043386 29d. Date signed (Month, Day, Year)

21201

8-25-10

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CUNTITED KARL 4:09 PM 2010 MUG 29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOW MAD GUNTY GENTRAL INSPITAL Counsia 1tomaro 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 22, 1931 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 M 2 F 215-34-9159 79 И. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, if the Medical Examine must be removed any injury or other traumatic event. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location MD **Ellicott City** Director Howard 1 □Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10389 Lombardi Dr. 21042 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates; Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Plant Engineer Catalyst Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Karl Ludwig Brand Hilda Schroeder မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Brand 10389 Lombardi Dr. Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory, LLC Sep 01, 2010 Glen Burnie, MD 4 Deponation 5 ☐ Other (Specify) ture of Juneral Service J censee 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 MOOS >1 art1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair re. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final **Physician** SEPTIC SINDER dis ase or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CLUSTRIDIOM CULITIS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tra resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnent at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnency in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ AWTZ ROMM FAIRURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed NESPILAZORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ ₩6 1 □Yes 2 110 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ N 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 1 28b. Time of 28d. Describe how injury occurred 5 Pending investigation To the rivers after death.

To the Funeral Director: After the funeral phy the funeral by the further than t 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ىك 036974 AUG 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 CHALTER OR #310 O. NYAMTOM NO coungia mo 21044

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 10 Physician/ 6:45 PM AUGUST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL INAI ALTIMORS CIT 8. Date of Birth (Month, Day, Year) 1936 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Ukraine Months Hours Director 74 216-39-4629 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ¥ Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Rohopin 5906 Park Heights Ave., Apt. 21215 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Neurological Deptpartment Head Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Maria Briduk Boris Borodin permit. Page 1 and 2 shoul Department of Health and I Important: If item 27 is m. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2108 Gores Mills Road, Reisterstown, MD 21136 <u>Boris Borodin</u> Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2 ☐ Cremation 3 ☐ Removal from State injury ( 4 Denation 5 Dother (Specify) Saints' Cemetery 9/2/2010 Reisterstown, MD 21. Signat f Fun al Se 22. Name and Address of Facility 11824 Reisterstown Road Wayne Osterling Eline Funeral Home Reisterstown, MD 21136 23a. Pa complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Enter the ock, or heart failu Immediause (Final disease or contilior resulting in death) pulmona Ry Physician. Medical Due to (or as a consequence of) Examiner ARDIOMYOPATHY Sequentially list conditions Examine if any, leading to immediate Cause (Disease or iinjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) ☐ Pregnam
☐ Unknown Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy 25. Was case referred to medical examiner?

1 Yes 2 O Be 26. Place of Death (Check only one) Hospital Other: မ 4 Nursing Home 5 Residence 6 Other (Specify 1 Shipatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? \_1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred ☐ Watural injury 5 Pending Accident within 24 hours after death

To the Funeral Director: /
completed filled in by the I Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tit 29d. Date signed (Month, Day, Year) 63430 AUGUST 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OF BALTIMONE RAVITEJ こってててこう 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

0220

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 27539

		T- For State Registrar		C	ertifica	ate of	Death			R	eg. No.			
Physicia Vedical Exami	an/	Decedent's Name (First, Midd	Glo	oria	Cr	aigh				Date of Dea Month August 28	Day	Year		3. Time of Death 2319 hrs
•		4a. Facility Name (if not institution MD General Hospital	on, give street and nu	imber)		41	o. City, Town, o Baltimore	Location	of Death		4c. (	County of	Death	
Funeral Director		5. Social Security Number 355–44–6845	6. Sex	7. Age (In yrs	. last birth		If Under 1 Yes		er 24Hrs.	1			9. Birth Cour	
		Usual Residence of Decedent	1 M 2 X F			Yrs.				8-5-	1949			LA
w any		10a. State 10b. County			•	or Locatio		-			-			10d. Inside City Limits
daryland 28a-f show 1 at once.	ţ	MD  10e. Street and Number	na	В	alt	imor				<del> </del>	0 0''	- ()		1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho he notified at once.	Director						10f. Zip Code			1	0g. Citize			ny?
with the notion of the notion		456 Manse Ct	12. Was Dec	edent Ever in	U.S.		2120 Decedent of Hi	spanic Ori					Americ	an Indian, Black,
r death	by Funeral	1 Never Married 2 X M 3 Widowed 4 Div	arried Armed Fo	2 X No			f Yes, specify Cuban, Mexican, Puerto  Yes 2 X No specify:			ican, etc.)	s	White, pecify:		ack
5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examiner	ed b	15. Decedent's Education (Spe					s Usual Occupa st of working life				16b. Kir	nd of Bus	iness/In	dustry
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)		_				~,	Tu	rf	Val	ley
5-0036 led within 7 Hygiene. I other than the Medica	5	11th grad 17 Father's Name (First, Middle	Last)			нои	sekeer		's Name (F	First, Middle, I	Maiden Si	urname)		
	Be	Andrew Smit			1.0					e Mar				
<b>○</b> 등 등 등	의	19a Informant's Name/Relations Estelle Smit	hp(Type, Print) h-M		_11_4	456	Address (Stre Manse	Ct		ral Route Nur LO, MI			, State, i	Zip Code)
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27		20a. Method of Disposition  1		20b		f Dispositi ory or othe	on (Name of ce er place)	metery,		Date		cation - (	City or T	own, State
Baltimore, Department of Her Important: If ite	-	4 Donation 5 Other Specify: Mt Carmel Cem 9-								-2010 Balto, MD arch East F/H				
Depa Depa Impo	ļ	2) A C	Licensee				Ol E.					lto		D 21202
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca on each line.	aused the dear	th. Do not									Approximate Interval Between Onset and
taminer	1	Immediate Cause (Final disease or condition resulting in death)	a. Atheroscler			ar Dise	ase						-	Death
		Sequentially list conditions,	b	120 - 10 - 10										
	Examine	if any, leading to immediate cause Fiter Underlying Cause (Disease or injury that initiated	Due to (or as a										-	
cuted nd transit		events resulting in death) Last	Due to (or as a	consequence	of):			_						
18760, rificate be executed ng physician and as the burial - transit	n/Medical	UNPENDED	AMENDED											
<b>∞</b> = ∞ ≈	Š	IF FEMALE: 23b. Was decedent pregnant in th		outcome of pre irth	egnancy 2	Feta	I death 3	Ectopie	c pregnanc	ev		Date of d	lelivery Da	av Year
	Physicia	past 12 months?  1 Yes 2 ✓ No 9 Unit	4 Pregn	ant at time of o			er (Specify)		- F S	•				,
that the de detached for	Phy	Part II. Other significant condit	9Unkno		resulting	in the un	derlying cause	given in Pa	art I.	23e. Did to	obacco us	e contrib	ute to th	ne cause of death?
ires that the signed by	<u>a</u>	Remote Brain Aneury								1 Yes	s 2 🗌 l	No 3	Proba	ibly 4 🗸 Unknown
of Vital Records, ag Physician: The law requiring the this certificate has been sineral director, page 2 should be	Completed									24a, Was autop				ppsy findings available mpletion of cause of
Reco The law cate has	E										rmed? 2 ✓ No	de 1 [	ath? Yes	2 No
tal Rec	8	25. Was case referred to medical examiner?	11.		<b></b>			of Death Other	(Check on					
ing Physical Control of View Physical Original Physical Physical Original Physical P	의	1 ✓ Yes 2 No 27. Manner of Death	28a. Date (Month,	npatient 2 vo		tpatient ime of Inj		ry at Work		Home 5 8d. Describe			Other:	
ion (tending eath.	틽	1 Natural 5 Pend 2 Accident Inves	(Month, stigation	Day, Year)			1	Yes 2	No		, ,			
Division of Vital Records, P.O. Box 6 within 24 hours after death. The law requires that the death centifin 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Certification:	3 Suicide 6 Coul		e of Injury - At	home, far	rm, street,	factory, office I	ouilding, et	c. 2	8f. Location (S or Town, S		Number	or Rura	al Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire	Medical C	29a. Certifier 1 Certifying Pt	nysician: To the bes											
To with	Mec	29b Signature and title of certifie	and manner st				29c. Licens							h, Day, Year)
		1 a Julie	NO		00 :		O.C.	M.E.			Augu	st 29, 2	2010	
			ssistant Medica	Examiner	111	Penn S	Street, Baltin	nore, M	D 21201	1				
Sta Registi	ate rar	31. Da SEP 0 2 2010	32. Re	gistrar's Signa	par	4)								
												_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary A. Chiumento Month August 7:10 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Ye 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2√XF Months Days Hours Min. 216-07-4314 Director Yrs Usual Residence of Decedent Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1XX Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4214 Edgehill Avenue 21211 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3√√√√ Widowed 4 □ Divorced Specify white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Wells Amelia Blucher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Reynolds (Daughter) 4214 Edgehill Avenue Balto, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/3/2010 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burgee Henss-Seitz Fune 3631 Falls Road Balto. Funeral Home alto, MD 212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to ( as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a sonsequence on: attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Certificate: To Be Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide s after death. 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

State Registrar

a a ...

31. Date filed (Month, Day, Year) SEP 0 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANCES

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Charles Edward Carter, Sr. Physician/ Month 10:45 PM Avanuse 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore HOSPITAL OF BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 XXM 2 🗆 F Hours June 15, 1934 216-30-1110 Yrs. Director 76 Usual Residence of Decedent 10a. State 10b. County 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MdN/A Yes 2 No Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1202 West 42nd Street 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married XX Married 1 WYes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White Specify: Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer City of Baltimore other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilford L. Carter Frances Ensor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. Carter (Wife) 1202 West 42nd Street Balto, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 09/04/2010 Timonium, MD 21. Signature of Funeral Service Dc .22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, 3631 Falls Road Balto, MD 2121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardia disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Vear 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No Hospital or Attending Physician; 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pendina 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Arshbreet Kaur. RES-OOC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sto

Charles

Registrar SEP 0 2 2010

31. Date filed (Month, Day, Year)

SINAL

HOSPITAL OF

MBBS.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

					aryland / Den Ce	02/2010 dille rtificate of De	alth and Me eath	ental Hygie		27542	
	Physicia		1. Decedent's Name (First, Middle, La James H. Colliso	•				2. Date of Death Month August	2010 2 <sup>ty</sup> 2 <sup>tor</sup>	3. Time of Death 9:45 A м	
	Medic Examir		4a. Facility Name (if not institution, giv	e street and number)		4b. City, Town, or Lo			4c. County of De	ath	
	Funeral		Stella Maris Hos  5. Social Security Number 6.		e (In yrs. last birthday)		f Under 24 Hrs.	8. Date of Birth	Baltim 9.8		
	Director		216-24-3260 Usual Residence of Decedent	1 <b>⊠</b> M 2 □ F	73 Yrs.	Months Days	Hours Min. A	prii Day Ye	<sup>ear)</sup> 1937	irthplace (State or Foreign country UNK	
	/land f show ed at	tor	10a. State 10b. County MD		10c. City, Town or Lo					10d. Inside City Limits	
	ne Mary or 28a- onotifie	Direc	10e, Street and Number		Baltimo	10f. Zip Code		100	1 ☐ Yes 2 ☐ No Citizen of What Country?		
	n with the same is 23a and inst be	neral	1124 Newcome W	ay		21205		100	USA	outing ?	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Funeral Director	11. Marital Status unk 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.	No	Was Decedent of Hispa If Yes, specify Cuban, I 1 ☐ Yes 2 🌠 No 3	Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.	
1215-(	ithin 72 hor ene. • than "nat he Me Jica	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12) unk		(Give	dent's Usual Occupation kind of work done during ONOT use retired)	on <b>unk</b> ng most of working	7	b. Kind of Busines	s Industry <b>unk</b>	
land 2	d be filed w fental Hygi irked other tic event, t	To Be (	17. Father's Name (First, Middle, Last)	_		18	8. Mother's Name (	First, Middle, Maid	den Surname) un	ık	
Baltimore, Maryland 21215-0036	nd 2 should ealth and N m 27 is ma ner trauma		19a. Informant's Name/Relationship ( Shirley Fitch			ng Address (Street and 7 Stillwate					
timore	t. Page 1 a tment of H tant: If ite ijury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☒ Other (Spec	<sub>ify)</sub> in state		natory or other place)	Date 20c. Location - City or Town, State  dress of FacilityState Anatomy Board				
Ba	permir Depar Impor any in		21. Signature of Funeral Service Licer Ronal C	Wade / Dire	¢tor 22					, MD 21201	
- P	Physician/		23a. Part Enter the disease or con shock, or heart failure. List only Immediate Cau. (Final disease or condition	one cause on each line	the death. Do not enter.				170	Approximate Interval Between Onset and Death	
_	Medical Examiner		resulting in death)		a consequence of):	JAMES THEOR	DINIO DA	HOOM			
-	it d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Oue to (or as a	s consequence on:						
	cate be executed physician and the burial-transit	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):						
09	ate be on the physicial the bur	edical		d							
Box 687		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d	elivery Day Year	
s, P.O.	ures that th signed by Id be detac	þ	Part II. Other significant conditions	contributing to death be	ut not resulting in the u	nderlying cause given	in Part I.			o the cause of death?	
Vital Records,	sician: The law requision of the size of t	Completed						24a. Was an autopsy performed 1 \( \text{Yes} \) 2 \( \text{X} \)	prior to	utopsy findings available completion of cause of	
tal	ician: 1 certifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:			of Death (Check o		UNO 1 TO TE	95 2 LINO	
o	g Phys er this neral dii	te: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 ☐ Inpatie 28a. Date of injur (Month, Day	ent 2 ER/Outpatier y 28b. Time of injury	28c. Injury at		e 5 Residence	-	cify) HOSPICE	
lon	ttendin death. stor: Aft the fur	Certificate:	1 🛣 Natural 5 🗌 Pending 2 🗐 Accident Investigatio 3 🗐 Suicide 6 🖂 Could not b	n			2 🗆 No				
Division of	tal or A rs after al Direc ed in by		4 Homicide determined	building, etc	ry - At home, farm, stre . <i>(Specify)</i>	eet, factory, office	28	f. Location (Street City or Town, St		ural Route Number,	
1	or the robstration of Attending Physicians: within 24 hours after death.  To the Funeral Direction After this certific completed filled in by the funeral director.	29a. Certifler (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifler (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifler (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	Mit To		29b. Signature and title of certifier	live V	John M	29c License nui	274C	) 29d	Date signed (Mont	23rd 2010	
			30. Name and address of person who  ERNESTINE WRIGHT		eath (Item 23a) (Type, P  DULANEY V		TIMONIU	M, MD 21	.093		
	Stat Registra	~	31. Date filed (Month, Day, Year) SEP 0 2 20	32. egistra	r's Signature	are					

9:47 a.m.

AUGUST 21, 2010

JAMES COLLISON #2

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27543 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 31<sup>Day</sup> 2010 Year 11:15 PM Critcher August Marquerite 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Towson 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8 Date of Birth 1 M 2 X Months Days Hours (Month, Day, Year) December 17, 1935 Mary land 213-32-3404 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Maryland 1 Yes 2 XNo Baltimore Overlea 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 1/2 East Elm Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 years 6 Years Education Vice Principal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marquerite Cecilia Flury Joseph Lee Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Critcher 1/2 East Elm Avenue, Overlea, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Septenter 1 Donation 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 3, 2010 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. Dundalk, Md. 7110 Sollers Point Road, 23a, Part 1, Enter the disease shock, or heart failure. List complications that caused the death op not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) PANCREATIC CANCER Due to (or as a consequence of)

Physician/ Medical Examiner

Important: If item 27 is marked other than "na any injury or other traumatic event. His "na once."

Physician/

Medical

Director

Funeral

þ

Completed

Be

Examiner

**Funeral** 

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

with the Maryland

Baltimore, Maryland 21215-0036

AUGUST

Completed by Physician/Medical Examiner B B |요

ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit

After this certificate

To the Funeral Director: After this certific completed filled in by the funeral director,

Hospital or Attending 24 hours after death.

Certificate:

27. Manner of Death

X Natural

Accident

4 Homicide

29a. Certifier

(Check

only one

29b. Signature and t

30. Name and a dre

of Vital Records, P.O. Box 68760

MARGUERITE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗶 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  9  Unknown		23d. Date of delivery  Month Day Year	
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	1	o use contribute to the cause of death?	
		24a. Was an autopsy performed?		ble of
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)		
1 🗆 Yes 2 🗶 No	Hospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hol	me 5 Residence	6X Other (Specify) HOSPICE	

28c. Injury at work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

within 24 hours a

State Registrar DHMH 17 Rev 7/2009

JACKIE JONES. CRNP 31. Date filed (Month, Day, Year)

5 Pending

Investigation 6 Could not be

determined

2300 DULANEY VALLEY RD.

28a. Date of injury (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of N	1arylan		artment of <i>tificate of</i>			/lental H		/ 11	10	27544
			Decedent's Name	e (First, Middle, La	st)			timodito or	Dogu		2. Date of I				3. Time of Death
	Physicia Medic		Margare	t	М.			Diver	s		Month 08	3	O 20	Year 10	9:25p. M
	Examir		4a. Facility Name (if	not institution, give	e street and number)			4b. City, Town,	or Locatio			4	4c. County	of Death	
					talou St				ltin						
	Funeral Director		5. Social Security No. 217-18-	6234	Sex I ☐ M 2 <b>X</b> F 7. A	ge (In <i>yr</i> s. Ia <b>97</b>	Yrs.	If Under 1 Year Months Day		der 24 Hrs. Min.	8. Date of I (Month, 02	Birth Day, Year <b>22</b>	13	9. Birth Coun	place (State or Foreign try)  PA
	nd how at	۱	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	laryla 3a-f s ified	ect	MD	NA			Balti	more						- 1	1 <b>X</b> Yes 2 □ No
	or 28	흐	10e. Street and Nun	nber		1	-	10f. Zip Code		-		10g. (	Citizen of W	hat Cour	ntry?
	s 23a nust b	Funeral Director	1809 No	rth Ben	talou St	reet			2121	6			U.	S.A	•
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	β	11. Marital Status 1 ☐ Never Marri 3 🏿 Widowed	ied 2  Married 4  Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 X If Yes, Give Year or Dates.			Vas Decedent of f Yes, specify Cu □ Yes 2 🟋			ecify Yes or N Rican, etc.)	0-		, White,	
5-0	hour fnatu dical	jet	(Sne	15. Decedent's E	Education		16a. Dece	lent's Usual Occi	upation	ost of work	ina	16b.	Kind of Bu	siness Inc	dustry
21	hin 72 ne. than '	Completed	8th grad		College (1-4 or	5+)	Ìife. D	O NOT use retire	d)	OST OF WORK	ng	Ι,	a - 6 - 1		
7	d with	Be C	17. Father's Name (		na		ма	nager	1		_		Cafet		a
anc	oe file	TO E									e (First, Midd	le, Maide	n S <i>ur</i> na <i>m</i> e)		
Z	ould k ind Me mark matic		Joe Gra  19a. Informant's Na	•	Type Print)		105 M-88	ng Address (Stree			iller	· 0'	- T - O	. 7	
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ē	1 and of Hea item othe		20a. Method of Disp	osition		20b. P	lace of Dispo	sition (Name of			Date		Location -		
Ę	Page nent c int: If			☐ Cremation 3 ☐ 5 ☐ Other (Speci	Removal from Stat	Ar	-	natory`or other pi Memor		9/4	/2010	A	butu	ıs.	Бм
alti	rmit. I partn porta y inju		21. Sign sture of Fur	neral Service Licen	see Charles	1		Name and Add				1			
<u>m</u>	9 9 E 8 9		yeru		mod!	PALN	${}$	300 Wa	bash	Ave	, Bal	time	ore,	Md	21215
			shork, or hear	t failure. List only d	plications that cause one cause on each lir	the death	. Do not ente	r the mode of dy	ing, such	as cardiac c	r respiratory	arrest,			Approximate Interval Between
	Physician/	8 9	Imme ia e Cause (I disea e / r conditio resulti in death)	Final n	En En	d51	AGE	den	rent	rA .					Onset and Death
	Medical Examiner		resultive in death)		Due to (or as	a consequ	ence of):								
		ا <u>ه</u> ا	Sequentially list conditions, if any, leading to inimediate  Due to (or as a consequence of).												
	ed nsit	dical Examiner	if any, leading to im cause. Enter Under Cause (Disease or i	dying	Due to (or as	a consequ	erice orj.								
	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Exa	that initiated events resulting in death) L	3	C. Due to (or as	a consequ	ence of):							$\dashv$	
09	s be e /sicial e buri	ical			d										
876	ificate ng phy as th	Med	IF FEMALE:												
Ğ X	n cert endir r use	an/l	23b. Was decedent		23c. If yes, outcome	of pregnar	ncy death 3 🗆	Ectopic pregna	ncv			- 1	23d. Date	of delive	ery
Bo	deat he at red fo	/sici	in the past 12 n 1 ☐ Yes 2 ☑ 9 ☐ Unknown	No No	4 ☐ Pregnant 9 ☐ Unknown			Other (specify)				.	Mon	th	Day Year
Ö	at the d by t etach	by Physician/Me		cant conditions o	ontributing to death	out not resu	Ilting in the II	nderlying cause (	niven in Pa	rt I	22a Did	tabaaaa	contrib		a course of death?
σ <u>.</u>	es tha		, are in Other digital	ount conditions o	onthibuting to death	Jul Hot 1630	ating in the a	idenying oddse (	giveninia						e cause of death?
ğ	requir	Completed													
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<u> </u>	n: Th ificate or, pa		25. Was case referre	d to medical				26	Diago of D		1 🗆 Yes	2 4		☐ Yes	2 No
Vita	/sicia s cert directe	To Be	examiner? 1  Yes 2	. / 11	Hospital:	ient 2 🗆 I	ER/Outpatien	_ Ot	her:	eath (Check	me 5 Res		c $\square$ Oth	(016.)	
of	g Phy er this		27. Manner of Death		28a. Date of inju	ıry	28b. Time of injury	28c. Inju	ıry at		28d. Describe				
on	ath. pr: Aft	lical	1 Natural 2 Accident	5 Pending Investigation	n	y, rear)	Injury		rk? ⊒Yes 2 l	□ No					
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In	ury - At hor c. <i>(Specify)</i>	ne, farm, stre	et, factory, office		1	28f. Location City or To			or Rural	Route Number,
	spirtal ours a remal I		29a. Certifier 1	Vertifying Phys	sician: To the best o	my knowle	udge death o	coursed at the tim	o data an	d place and	d due to the c	201100(0)	and manner	- constato	
	e Hos 124 h e Fun leted	Medical	(Check 2	Medical Exam	iner: On the basis of e se Practioner: To the	examination	and/or invest	gation, in my opir	ion, death	occurred at	the time, date	and place	e, and due t	the cau	se(s) and manner stated.
,	vithir To the		29b. Signature and t		Se l'ischoner. louic	DCSI OF ITTY	Kilowiedge, d	29c. Licen	se number		e, and due to		ate signed (		
				uarry	Imm (	)		D 3	351	02		Sen	temi	BEV	1 2010
1			30. Name and addre		completed cause of o	leath (Item :	23a) (Type, P	rint)			$\sim$ 1	-	1		100011 -
b			Hilow	y Don				orth c	Har	162	STREE	P	PYN	nbre	macylang
	Stat Registra	٠	SEP 0 2		32. Registr	ar's Signati	are						(		
DHM	1H 17 Rev 7/20		SEF U Z	2010	enver p		W. Commercial Commerci								
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							ORIGIN	W/NL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Marylan Himorp 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 🛣 Months Hours Min May 2 Day, Year, 1938 Washington DC 213-42-5694 72 Director Usual Residence of Decedent or 28a-f show 10c. City. Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 XXYes 2 □ No Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 3 Ridge Road, Unit D 20770 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XXIo Specify Specify: Caucasian 3 ☐ Widowed 4 ☒Xivorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) years Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick James Stevenson Lottie Elizabeth Crosley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trat Georgene Najafi daughter 4525 Hornbeam Drive Rockville, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State W.Arundel Crematory Sep 1, 2010 4 Donation 5 Other (Specify) Odenton, Maryland . Signature of Funeral Service Licensee <sup>2</sup>Bonandsch<sup>ss</sup> füneral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a Part 1 Enter the disease shock, or heart failure. List Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any teaching to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Box 68760 Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Circator After this certificate has been signed by the attending physician and completed illiedin by the Uneral director, page 2 should be detached for use as the burial-transit

24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No. Other: 1 Yes Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Greene

State Registrar

Medical

only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are L			
State of Maryland / Department of Health and Mental Hygiene	20	In	2754
Certificate of Death	20	10	_ / 0 :

		- For State Registrar								g, No.		
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle, Last  Marvin Kenneth  Kenneth Marv						Moi Aug	e of Death oth I gust 24,	2010	ear	3. Time of Death 1427 hrs
		4a. Facility Name (if not institution, give 633 Asquith Street Apt. 16			l l	. City, Town, or L Baltimore	ocation of			N	y of Death	
Funeral Director		5. Social Security Number 6. Se 219-75-7575	X 7 Age (li	n yrs. last birth $46$	nday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	ate of Birth $^{\prime}15/1$		Cour	place (State or Foreign htry) Yland
Maryland 28a-f show any d at once.		Usual Residence of Decedent  10a. State 10b. County  Md. N/A  10e. Street and Number	10	c. City, Town	alti	more			100	. Citizen of		10d. Inside City Limits 1 XYes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	633 North Ais	quith Str	et		21202	}		τ	SA		
ofter death will, or items	by Funeral	11. Marital Status  1	12. Was Decedent Even Armed Forces?  1 Yes 2 X If Yes, Give Year or Dates:	er in U.S.	If Yes	Decedent of Hisp s, specify Cuban, Yes 2 X No	Mexican, specify:	Puerto Rican,	etc.)	Specif	nite, etc. v: $f B$ ]	an Indian, Black,
2 hours a		15. Decedent's Education (Specify or Elementary/Secondary (0-12)	College (1-4 or 5+)			s Usual Occupations of working life.			one	16b. Kind of	businessin	dustry
5-0036 iled within 72 l Hygiene. 1 other than ",	ompleted	12			Pair							Loŷed
	Becc	17. Father's Name (First, Middle, Last)  Willie Davis				[		s Name (First, Ctoria		_	ne)	
- 8 P 19 15		19a. Informant's Name/Relationship (T	ype, Print )		•	Address (Street	and Numb	ber or Rural R	toute Numb			
e, MD I and 2 sho Health and item 27 is	-	Victoria Davis 20a_Method of Disposition		20b. Place o	of Disposit	ion (Name of cerr		Dad, E		more 20c. Locatio		. 21225 Town, State
more		1 X Burial 2 Cremation 3 Donation 5 Other Specify:	Removal from State		ory or othe	erplace) Star Ce	m F	3/31/2	2010	Balt	imore	e. Md.
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other to		21. Signature of Funeral Service Licen							PA Md.21217			
Physician	$\neg$	28a. Part I. Enter the disease, or comp failure. List only one cause on ea		death. Do no	ot enter the	mode of dying,	such as ca	ardiac or respi	ratory arres	t, shock, or	heart	Approximate Interval Between Onset and
/Medical aminer	1	Immediate Cause (Final disease a.	Hypertensive Athe		Cardio	vascular Dis	ease					Death
	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):								
d sit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ience of):	_	•		_	_	_	29	
executed an and al - transit		d. UNPENDED	AMENDED #1		<b>^-</b> ^	10.10010						
1760, ficate be exe g physician a	Medi	IF FEMALE:	#1pe	of pregnancy		/2/2010,			-	23d. Date	of delivery	
Sox 687 leath certific e attending I for use as th	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time			aideath 3 [ er (Specify)	Ectopic	pregnancy		Month	) D	ay <b>Y</b> ear
Box 68 e death certification the attending and for use as	hysi	1 Yes 2 No 9 Unknown	9 Unknown									
P.O. s that the gned by e detack	<u>آھ</u>	Part II. Other significant conditions  CHF, HTN, high choleste	-				iven in Pai	rt I. 2				he cause of death? ably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after cleath.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed								24a. Was ar autops		prior to co	opsy findings available ompletion of cause of
Reco	Ĕ							1	perform		death?	s 2 No
ital Recision: The rector, page	Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient	2 EB/O	utpatient		of Death (	(Check only o		Residence	6 🗸 Other	Scene
1 of Vi ting Physi After this funeral dir	٤	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year	28b.	Time of In		y at Work			ow injury occ		Occine
tendin tendin death. tor: A	ation	1 Natural 5 Pending 2 Accident Investigati	on				res 2	- 1				
Divis pital or A ours after teral Direc	Certification:	3 Suicide 6 Could not determine		y - At home, fa	arm, street	t, factory, office b	uilding, etc		ocation (Si or Town, St		mber or Rui	ral Route Number, City
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical (	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine)	ian: To the best of my k r:On the basis of examinand manner stated.	nowledge, de nation and/or i	ath occurr investigati	ed at the time, da on, in my opinion	ate and pla , death oc	ace, and due to curred at the t	o the cause ime, date a	(s) and man	ner as state ad due to the	ed. e cause(s)
E 3 E 3	Me	29b. Signature and title of certifier				29c. Licens O.C.I				29d Date s		nth, Day, Year)
		30 Name and address of person who Laron Locke MD. Assis	com <del>pleted</del> cause of dea tant Medical Exam		1 Penn	Street, Baltir	nore M	D 21201		-		
S	tate		32 Pagietrar's	Signature		Dailli						
Regis		AUG 3 1 2010	anna B	far	NE P							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AMonth Year Day 1310 M Physician/ 30 2010 Sherry Ann Dver Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Kensington 10211 Greenfield St. If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** July 22 1 M 2 XF Months Days 53 Vrs 217-70-3694 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Kensington Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 20895 10211 Greenfield St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No within 72 hours after death Black, White, etc. Completed by 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify. Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Higher Education 5+ Student Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H 27 is marked of traumatic ever Wynona Ann Head 2 William E. Dyer, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If item 27 is r or other tra 10211 Greenfield St. Kensington, MD 20895 <u>Wynona Ann Dyer</u> (mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept Date nent of 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Beltsville, MD 2010 4 Donation 5 Other (Specify) Chesapeake Crematory 22. Name and Address of Facility Rapp Funeral & Cremation Service Signature of Fun and Service Licenses 933 Gist Ave. Silver Spring, MD 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 < m/-Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examiner that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending physi for use as the b IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ Day in the past 12 months?
1 ☐ Yes 2 Z No Month Year Pregnant at time of death q Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed Yes 2 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 2 🗌 No ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending M Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi

State Registrar 31. Date filed (Month, Day, Year)

ome

OME

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 52 9

D00428

SILVER

5010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Delcher G. September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FutureCare Cherrywood **Baltimore** <u>Reisterstown</u> 8. Date of Birth (Month, Day, Year) June 3, 1918 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Country) Director 215-10-6035 92 June Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit, Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 200 Cork Lane, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Modeling Dept. Store years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symame) ပ James 0. German Bessie Mae Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Cork Lane #104 Reisterstown, MD 21136 Elizabeth Radebaugh (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Carroll Cremation, Ind 9-2-2010 Hampstead, MD 4 Donation 5 Other (Specify) of Fun ral Service Lic 22. Name and Address of Facility 11824 Reisterstown Road Wayne Osterling Eline Funeral Reisterstown, Home or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart ailure. List only one cause on vach line Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami executed for use as the burial-transit Cause (Disease Or ii that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 🗌 No the 9 Unknown 9 Unknown signed by Part H. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 Yes 2 No 3 Probably W Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? within 24 hours after death. To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 2 No Other: 1 🗌 Inpatient 2 🗍 ER/Outpatient 3 🗌 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

SEP 0 2 2010

DHMH 17 Rev 7/2009

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August **3**T<sup>ay</sup> 2010 2:20p M Eney, Η. Lloyd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Woodstock 2130 Ganton Green Apt. 103 If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours 1 X M 2 | F June 1, 1928 Maryland 82 216-24-4329 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗌 Yes 2 🕱 No Florida Collier Collier Naples 10g. Citizen of What Country? 10e. Street and Number Funeral 1319 Monarch Circle 34116 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Year or Dates. Korea 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Engineer Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Lloyd H. Elsie Bremmer Eney, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 308 Windsor Court, Lake Villa, Illinois\_60046 Mark E. Eney, Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/1/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. LUNG NEOPLASM set and Death Immediate Cause (Final MALIGNANT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Clarity for se a consequence of been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? NEUROPATHY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed? 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence 2 X No. မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d, Describe how injury occurred Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident ☐ Acciden☐ Suicide Investigation within 24 hours after death

To the Funeral Director: of the formula of the formu 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one)

2011

State 31. Date filed (Month, Day, Year)

ted cause of death (Item 23

SEP 0 2 2010

Server S. Harde

Registrar

23a) (Type, Print) T 97 STE. 10

GREMMOND

SEPTEMBER1, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ANN Physician/ DOROTHY **EDMISTON** 31, 2010 AUGUST 10:30P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner STELLA MARIS HOSPICE CENTER TIMONIUM BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 10-1-1936 1 🗆 M 2 🔀 F Hours 73 Yrs MARYLAND Director 217-32-9570 Usual Residence of Decedent fshow 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified BALTIMORE MD RASPEBURG 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? pe r items 23a ner must be Funeral 5104 McFAUL ROAD 21206 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ð If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT BOND DISTRIBUTING Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, CHARLES BAIER CATHERINE (FELTER) should be other traumatic 9a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5104 McFAUL ROAD BALTIMORE, MD 21206 PAMELA EDMISTON/DAUGHTER Page 1 and 2 permit. Page 1 and Department of Healf Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-3-2010 BALTIMORE, GARDENS OF FAITH 21. Signature of Funeral Service 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a. GIST TUMOR Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🗶 No Day Pregnant at time of death te has been signed by the age 2 shi uld be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 XNo 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗌 No 1 Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Certificate: To 1 ☐ Yes 2 🗶 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred s after dea.. •al Director: After •v the fe 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Μ 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONES.

31. Date filed (Month, Day, Year)

2010

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / De	partment of Health and	Mental Hygie	2010 27551
			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Death	. No. 3. Time of Death
	Physicia Medic		Mary Theresa Edelen		Month August	Day Year 27 2010 5:20 A M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	1	4c. County of Death
1	*-		Gilchrist Hospice Center	Towson		Baltimore
	Funeral Director		5. Social Security Number  6. Sex 1 □ M 2 ▼ F  7. Age (In yrs. last birthda)  Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 16,	9. Birthplace (State or Foreign Country) 1961 Maryland
	land show d at	r	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	laryla 3a-f s iified	Funeral Director	MD Howard Laure	1		1 ☐ Yes 2 ₩No
	the N	l Dir	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	s 23a	nera	9584 Kings Grant Road	20723		USA
	death ritem ner n	Fui	Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sport of If Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	e filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	ed by	1 Never Married 2XXMarried 3 Widowed 4 Divorced Year or Dates.	1 ☐ Yes 2🏋 No Specify:		Specify: White
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2	hin 72 ne. than '	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)	King	- 1.
	e filed wit tal Hygie ed other event, th	Be C	12th 4 17. Father's Name (First, Middle, Last)	Credit Manager	me (First, Middle, Mai	Banking  den Sumamel
Maryland	should be fill n and Mental 7 is marked of raumatic eve	욘	Thomas J. Windon	1 .		Splaine
a S	e 1 and 2 should be of Health and Ment: If item 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Ru		ty or Town, State, Zip Code)
	nd 2 s ealth m 27			84 Kings Grant Ro	ad, Laurel	, MD 20723
Baltimore,	ge 1 a nt of H it of H ite or oth		1   Burial 2 □ Cremation 3 □ Removal from State cemetery, c.	position (Name of rematory or other place)		c. Location - City or Town, State
	permit. Page 1 a Department of I Important: If ite any injury or of			y's Cemetery 9/2, 22. Name and Address of Facility Do		Laurel, MD
g	Depi Impo any	2. /	MO1103	313 Talbott Avenu		· ·
			23a. Part 1 Enter the disease, or complications that caused the death. Do not e shock or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
- 4	Tiysician	2 2	Immediate Cause (Final disease or condition	Carcer		Onset and Death
-	Medical Examiner		resulting in death)  ue to (or as a consequence of):			
		iner	Sequentially list conditions, if any, leading to immediate Course Enter Underthing.  Due to (or as a consequence of):			
<	cate be executed physician and s the burial-transit	Examiner	Cause (Disease or iinjury that initiated events c.			
_	ate be executed ohysician and the burial-transi		resulting in death) Last Due to (or as a consequence of):			
00/	icate   j phys is the	ledical	d			
200	ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 present 2  23c. If yes, outcome of pregnancy  1 □ Live Birth 2 □ Fetal death	B Ectopic pregnancy		23d. Date of delivery
, B0X	To the Hospital or Attending Physician: The law requires that the death certific, within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Physician/M		Other (specify)		Month Day Year
Z.	that the ned by detac	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ds,	quires en sig ould b	ted t			1 ☐ Yes	2 No 3 Probably 4 Unknown
Vital Records,	law renas be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
2	t The cate h				performe	d? death? No 1 Yes 2 No
<u> </u>	sician certif irecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	26. Place of Death (Che		e 6 Other (Specify) NOS ( Ce
5	g Phy er this neral d	te: To	27. Magner of Death 28a. Date of injury 28b. Time	of 28c. Injury at	28d. Describe how	7
0	eath. or: Aft the fur	ifica	1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	/ work? 1 ☐ Yes 2 ☐ No		
Division of	or Att after d Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, itate)
_	ospita hours uneral	Medical	29a. Certifier Certifying Physician: To the best of my knowledge, deal			
	the H hin 24 the Fu	Mec	(Check only one) 3 ☐ <b>Medical Examiner</b> : On the basis of examination and/or involved only one) 3 ☐ <b>Certifying Nurse Practioner</b> : To the best of my knowledg	e, death occurred at the time, date and pla	ace, and due to the car	use(s) and manner as stated.
_	Vit vit		29b. Signature and title of certifier	29c. License number	29d	Date signed (Month, Day, Year)
	.0		30. Name and address of person who completed cause of death (Item 23a) (Type	e. Print)		2011 21 2010
	10		AMON TCHARLES MD 67	OIN Charles	St Jon	my NOCI
	Stat Registra		31. Date file pho 2 2010 32. Registrar's gnature and	w		

11:47

AUGUST

ROMAINE FRANKLIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30°, August 20Î Joseph Philip Finizza 7:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3009 New York Avenue Halethorpe If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 MM 2 | F Months Hours Min. (Month, Day, Year) 6/28/42 Massachusetts Director 030-30-0113 **Yrs** 68 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 No MD Halethorpe Baltimore 5 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 3009 New York Avenue 21227 USA 12. Was Decedent Ever in U.S. Armed Forces?

1. ✓ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 5 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates. Vietnam White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Warehouseman Warehouses Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Jospeh Finizza Mary Iovenio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i <u>Mrs. Barbara R. Finizza</u> 3009 New York Ave. Halethorpe. other Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any Injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland Park Cemetery 9/2/10 oudon 22. Name and Address of Facility Loudon Park Funeral Home Signature of Funeral Service Lic 3620 Wilkens Ave. Baltimore, Maryland 23a. Part 1. Enter the disease, or o shock, or heart failure. List of mplications that caused the o ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition Qnset and Death Priysician/ Medical resulting in death) Examiner Sequentially list conditions, if any, Lading to immediate cause. Enter Underlying Physician/Medical Examiner Due to jor as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? Yes 2 No death? certificate 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 🗙 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending I Director: And in by the fu Accident
Suicide М Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined in 24 hours the Funeral Dire City or Town, State) Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie ٥ 010

Registrar

SEP 0 2 2010

ame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

10-06366 James Fish

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	0 1
State of Maryland / Department of Health and Mental Hygiene	2/554
Cortificate of Dooth	

		Registrar Certificate of De	eam 		j. No.				
Physici Medical Exam		1. Decedent's Name (First, Middle,Last)  James D. Fish		2. Date of Death Month August 13,	Day Year 2010	3. Time of Death 1351 hrs			
			ity, Town, or Location of Deatl akoma Park	n	4c. County of Death Montgomery				
Funeral Director		406-70-3219 1XM 2F 58 Yrs.	Under 1 Year If Under 24Hrs Ionths Days Hours Mir		(MM/DD/YYYY) 9. Birt Foreig Cou	hplace (State or n Fort Campbell untry) KY			
ow any		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location				10d. Inside City Limits 1 X Yes 2 No			
uyland Sa-f sho	Director	Kansas Geary Junction Ci	f. Zip Code	100	j. Citizen of What Cour				
h the Ma 23a or 28	I Dire	135 East 11th Street	66441		USA				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Maryland Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	1 Never Married 2 Married Armed Forces? If Yes, sy 1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year	cedent of Hispanic Origin? ( Specify Cuban, Mexican, Puerto		14. Race - Americ White, etc. Specify: Whi				
hours a natura čxamin	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Us	sual Occupation (Give kind of f working life, DO NOT use ret	work done 1					
0036 within 72 liene. er than "!	Completed	Selementary/Secondary (0-12) College (1-4 or 5+) Proper	ty Manager		Private				
215-1 be filed ntal Hyg rked oth	Be Co	17. Father's Name (First, Middle, Last)  Jesse L. Fish	18.Mother's Name	•	, Middle, Maiden Surname)				
MD 21 d 2 should th and Me a 27 is ma	To	John Landen / Brother-in-law 7620 Whi	ress (Street and Number or I ispering Wind						
TOFE, ages lant of Heal t: If iten other tra		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Departies 5 Other Secritical Metropolitan	ace)	Date 20c. Location - City or Town, State 1/2010 Alexandria, Virginia					
Saltin ermit. Pe epartmer mportan		21. Signature of Funeral Service Licensee 22. Name	and Address of Facility		739 Baltim	ore Avenue			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo failure. List only one cause on each line.	Hyattsville t, shock, or heart	Approximate Interval					
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a Complications of remot Due to (or as a consequence of):	e shotgun wou	nd		Between Onset and Death			
'	e	Sequentially list conditions, if any, leading to immediate  b							
	an/Medical Examine	Course. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):							
760, icate be executed physician and the burial - transit	calE	d.  AMENDED 27 29 5							
8760, tificate be ing physicia as the buria	Jed i	IF FEMALE: 23c. If yes, outcome of pregnancy	g909 11/30/10	) TT	23d. Date of delivery				
6876 vertificate ading physe as the	an/N	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal dea	ath 3 Ectopic pregna	ncy	Month Da	ay Year			
P.O. Box 68 st that the death cert greed by the attendir	Physicia	1 Yes 2 No 9 Unknown 9 Unknown Other (S		· · · · · · · · · · · · · · · ·					
(i) (ii)	ğ	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.		cco use contribute to the 2 No 3 Proba				
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of			
tal Recian: The certificat		25. Was case referred to medical	26.Place of Death (Check of	1 Yes 2	No 1 ✓ Yes	2 No			
Vital hysician: this certif	o Be	examiner?  1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	TOther -	g Home 5 Re	sidence 6 Other:				
ion of tending Pheath.	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how					
Division tal or Attendi rs after death. al Director: A	Catic	Accident Pending   2/1967   unk	1 Yes 2 XNo		shot while				
Divisity or At ours after dours after dinect filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Woods		or Town, State					
Division  To the Hospital or Attention within 24 hours after death To the Funeral Director:	Medical (								
F 7 5 8	Me	and manner stated.  29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mont	h, Day, Year)			
	O.C.M.E. August 24, 2010								
end		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
St Regist	ate rar	31. SE pd (1021, 2016) 32. Registral Signal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
te Amend Items 23aPtII,25 per me,g907,09/01/2010dhb
Certificate of Death

Reg. No. 2

		1 - State Amend Items Registrar	23art11,25 p	per me g	tificate of L	Death Dani	) Re	g. No.	2/555
Physic	ian/	Decedent's Name (First, Middle, Last     Michael David	Gutin	-			2. Date of Death Month	22 2010	3. Time of Death 4.15 P M
Med Exam		4a. Facility Name (if not institution, give s			4b. City, Town, or	r Location of Deat		4c. County of De	
Funera		5. Social Security Number 6. Se	HOSPITAL 7. Age (In vin	s. last birthday)	South If Under 1 Year	more If Under 24 Hrs	■ 8. Date of Birth	9 1	Birthplace (State or Foreign
Directo		212-76-9843	7. Age (In yr.		Months Days	Hours Min.	April 16	, 1958	Maryland
and show	tor	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Loc	eation				10d. Inside City Limits
• Mary • 28a-f notifie	)irec	MD Anne Arı	undel Ga	ambrills					1 Yes 2 No
with the 23a or	Funeral Director	10e. Street and Number 928 Crofton	Valley Dr:	ive	10f. Zip Code 21054			og. Citizen of What	Country?
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ※ Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.	lf	Vas Decedent of H Yes, specify Cuba	ın, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Black, WI	nerican Indian, nite, etc. white
15-0 72 hour n "natu ledical	Completed by	15. Decedent's Ed (Specify only highest grad	de completed)	(Give k	ent's Usual Occup rind of work done of NOT use retired)	during most of wor	king 1	6b. Kind of Busines	ss Industry
212 within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5+)		driver			Transp	ortation
and be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)  Albert Gut	tin			18. Mother's Nai	me (First, Middle, Ma Bernice	aiden Surname) H <b>enrich</b> :	S
Maryland 21215-0036 12 should be filed within 72 hours after alth and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam		19a. Informant's Name/Relationship (Typ. Nichole Velez-daug		19b. Mailin 4020		and Number or Ru Jack Cr	ral Route Number, C	City or Town, State,	Zip Code) 21122
		20a. Method of Disposition  1 ☐ Burial 2X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		sition (Name of natory or other place Cremetor)		Date 2 24, 2010	Oc. Location - City  Glen Bu	
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Fureral Service License		22.	. Name and Addres		orose Fun		Inc.
	30	23a. Per 1. Enter the disease, or comp	olications that caused the de		328 Su1pl	hur Spri	ng Road Ar	rbutus MD	21227 Approximate
Physician		shock, or heart failure. List only on Immediate Cause (Final	ne cause on each line.	· hora	1001	10.1			Interval Between Onset and Death
Medica	1	disease or condition resulting in death)	a. Tue to (or as a cons		nial t	olled			18 days
		resulting in death)  Sequentially list conditions,	b	equence of):	max e		L.		18 days
Medica Examine		resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consi	equence of):	mal e		A LA	EXMINER	IF days
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Medica Examine	Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consi	equence of): อัจนีปราชอิงก <sub>ร</sub> ู้.	max e		VANDAM R. WEDCH	EWINER	1Fdays
EX 600  Examine physician and as the burial-transit	/Medical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a consi	equence of): equence of): equence of): gnancy etal death 3 □	Ectopic pregnand Other (specify)	Confession (	A CONTROLLAR MARCH	23d. Date of o	le earys
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or Vital Records, P.O. Box 68/60  ig Physician: The law requires that the death certificate be executed  ig Physician: The law requires that the death certificate be executed  ig The second of the control of the cont	To Be Completed by Physician/Medical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions conditions conditions conditions conditions are conditions.  Cocaine Use  25. Was case referred to medical examiner? 1   Yes   2   No   27. Manner of Death 1   Natural   5   Pending   2   Accident   Investigation   3   Suicide   6   Could not be determined  29a. Certifier   Certifying Physical Examinations   1   Certifier   Certifier   Certifier   Certifier   1   Certifier	b. Due to (or as a consider.)  23c. If yes, outcome of predictions a consider.  23c. I	equence of):  equence of):  equence of):  equence of):  equence of):  equence of):  gnancy  etal death 3 □ of death 5 □  resulting in the undersection of the original	26. Plate 3 DCA Other M 28c. Injury work 1 det, factory, office coured at the time gation, in my opinic	ven in Part I.  ace of Death (Che er: 4  Nursing H y at ?? Yes 2  No	23e. Did toba  1  Yes  24a. Was an autopsy perform 1  Yes 2  ck only one)  come 5  Residen  28d. Describe how  28f. Location (Stre City or Town,  and due to the cause at the time, date and	23d. Date of of Month    Coco use contribute   2   No 3	delivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available o completion of cause of? (es 2 No  Bural Route Number,  stated. e cause(s) and manner stated. anth, Day, Year)
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit of St.	Medical Certificate: To Be Completed by Physician/Medical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions con	Due to (or as a const  C. Due to (or as a const  d. 23c. If yes, outcome of prec  1	equence of):  eq	Ectopic pregnance Other (specify)  26. Plate 3 DOA Other 28c. Injury Work M 1 = 28c. Injury et, factory, office coured at the time gation, in my opinical transported to the course of t	ven in Part I.  ace of Death (Che er: 4  Nursing F yet 2  No  n date and place, a on, death occurred a lime, dots and place enumber  7005	23e. Did toba  1  Yes  24a. Was an autopsy perform 1  Yes 2  ck only one)  come 5  Residen  28d. Describe how  28f. Location (Stre City or Town,  and due to the cause at the time, date and	23d. Date of of Month    Coco use contribute   2   No 3	delivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available o completion of cause of? (res 2 No  Bural Route Number,  Stated. e cause(s) and manner stated. as stated. as fall of the probable of

DHMH 17 Rev 1/2001

State

Registrar

Ridge Road Weston

30. Name and address of person who completed cause of death (Item 23a) (Type\_Print)

SEP 0 2 2010

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS#10e,f,perFH,G907,9716/2010,ws
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.2 0 Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mon Medical et and number) 4b. City Town, or Location of Death 4c. County of Death Examiner BaHIMORE Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State Country) **Funeral** 1 🗆 M 2 🗙 F Hours Month Day 75 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City Town or Location Ralfimore 10a. State 10b. County 10d. Inside City Limits **Funeral Director** 1 X Yes 2 □ No 10e. Street and Number 1006, Upnor 10g. Citizen of What Country? Røad Avandale USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Completed by Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Sollege (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last (First, Middle 2 (Type, Print) Daughter Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature uneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ collapse Ovascular disease or condition resulting in death) one house Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hypertension been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mellitu. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after deam.

To the Funeral Director: After this certificate has in completed filled in by the funeral director, page 2: autopsy performe 1 Yes 2 XN Yes 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 \( \triangle \text{Nursing Home} \) 1 Nursing Home 3 Nursing Home 6 \( \text{X} \) Other (Specify Home) Daughter's Certificate: To 1 Yes 2 XNO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be ☐ Accident ☐ Suicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2**9**b. 29d. Date signed (Month, Day, Year) D0058860 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) yl BALTO, MD suite sss 3333 N. CALVERT ST. SHAWN MD DITICION 21218 31. Date filed (Month, Day, Year) Registrar's Signa State SEP 0 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#operFH, G907, 9/8/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical titution, give street and number **Examiner** 7. Age (In vrs. last birthdav. **Funeral** 8. Date of Birt Months **Director** 3a or 28a-f show t be notified at 10a, State 10b. County 10d. Inside City Limits Director Baltimore Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral "natural", or items 23a traumatic event, the Medical Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married \$ 1 Yes 2 No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 📉 No Specify 3 ₩idowed 4 □ Divorced Hack Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. oonday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ၉ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked nip (Type, Print) injury or other Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) Burial 2 Cremation 3 Removal from State 21. Signatur Frank er icensee any 23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as t the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo. Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s certificate has autopsy pertorm death? Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛱 Natural 5 Pending work? 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 5 who completed cause of death (Item 23a) (Type State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James Irvin Holley,	Jr. S	tate of Maryland		it of Health e of Death		lental Hy		2010	27550	
Physician/	Registrar  1. Decedent's Name (First, Midd	dle,Last)		e oi Deaiii	-	[:	2. Date of Deat	g. No. <u>C. U. I. U.</u> h	3. Time of Death	
Medical Examiner		James I	rvin Hol	ley, ј	r		Month August 31	Day Year , 2010	1436 hrs	
	4a. Facility Name (if not instituti 18 Barnacle Court	on, give street and number	r)	4b. City, To Baltime		tion of Death		4c. County of Death Baltimore Cou		
Formul	5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthda			Under 24Hrs.	8. Date of Birt	h(MM/DD/YYYY) 9. Bir		
Funeral Director		1XM 2F	52	Months Yrs.		lours Min.		Foreig		
	220-64-7284 Usual Residence of Decedent	123111 2								
* any	10a. State 10b. County	,	10c. City, Town or	Location					10d. Inside City Limits	
-f shore		lto	Essex	1,00				Oiline of Mines Com	1 Yes 2 XXNo	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 18 Barnacle	Ct		10f. Zip 0	1221			Og. Citizen of What Cou USA	ntry ?	
or death with , or items 23 . must be no	11. Marital Status 1 Never Married 2 K	12. Was Deceder		<ol> <li>Was Decedent</li> <li>If Yes, specify</li> </ol>				14. Race - Amer White, etc.	ican Indian, Black,	
ter dea		1 X Yes	2 No	1 Yes 2	X No SDE	ecifv:		Specify: Black		
ours aft	15. Decedent's Education (Sp	or Dates:	ompleted) 16a. Dec	cedent's Usual O	ccupation (0	Give kind of wo		16b. Kind of Business/Industry		
5-0036 de within 72 hours afted within 72 hours after than "natural" the Medical Examine Completed by	Elementary/Secondary (0-12		r 5+)	ing most of worki .ntenan	_			John Ho	pkins	
-003 within giene. her th	12th grade 17. Father's Name (First, Middle		Mai					laiden Surname)	_	
215. 215. ntal Hy rked of	James Holle						y Woo			
21; nould the Mer is mar fite eve	19a. Informant's Name/Relation		181	_				ber, City or Town, State	, Zip Code)	
MD and 2 sho saith and 2 sho saith and 2 sho saith and 27 is raumati	Phyllis T.  20a. Method of Disposition	Holley-Wif		Barna isposition (Name			Date M	D 21221  20c. Location - City or	Town State	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 XXBurial 2 Cremation 4 Donation 5 Other 5	Specify:	Garris	or other place)	est	9-9	-2010	Owings M		
Balt permit. Depart Import Injury	21. Signature of Funeral Service	e Licensee		22. Name and A				ast F/H Balto, M	n 21202	
Physician	23a. Part I. Enter the disease, of		d the death. Do not e	1101 E					Approximate Interval	
Medical	failure. List only one cause Immediate Cause (Final diseas	Acuto D	neumonia						Between Onset and Death	
LAAIIIIIEI	or condition resulting in death)	Due to (or as a con	sequence of):							
Jer Jer	Sequentially list conditions, if any, leading to immediate	b Due to (or as a con	sequence of):							
amir	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.	sequence of):							
re executed cian and inal - transit dical Examiner	events resulting in deathy East	d.					. 10			
68760, certificate be executed nding physician and se as the bunal - transisian/Medical E.	X UNPENDED	XAMENDED P	3a,pt.II,2 I per ME	2/ per m g910 12/	e 890 6/10	8 10-13 TT	3-10 vt			
Box 68760 e death certificate be the attending physical for use as the buthysical for use as the buthysician/Me	IF FEMALE: 23b, Was decedent pregnant in		ome of pregnancy	Fetal death	3 E	ctopic pregnan	су	23d. Date of deliver	/ Day Year	
x 6. th cert ttendir tr use a	past 12 months?	atomorphis	at time of death 5	Other (Specif						
). Box 68760 the death certificate by the attending physiched for use as the burnel Physician/Me	Part II. Other significant condi	a C OUKUOWII	ath but not resulting in	the underlying o	ause niven	in Part I	23e Did to	bacco use contribute to	the cause of death?	
Division of Vital Records, P.O. Box 68760, and reading Physician: The law requires that the death certificate be executed its after death.  al Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be deached for use as the burial - transit ertification: To Be Completed by Physician/Medical Exertification: To Be Completed by Physician/Medical Exertification:	Chronic Alc	•	ar par nor resulting in	and directlying e	adoo giroii			2 No 3 Prol		
rds, require been si nould b	Hypertrophi	c cardiomyo <sub>l</sub>	athy				24a. Was a		topsy findings available completion of cause of	
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of Vital Records ing Physician: The law required this certificate has been uneral director, page 2 should in: To Be Complete	25. Was case referred to medic	al		26	Place of De	eath (Check or				
F Vita Physician r this control of To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat		atient 3 DO		1		Residence 6 🗸 Othe	Scene	
n of ding P After funera	27. Manner of Death  1 X Natural 5 Per	28a. Date of In (Month, Day	jury 28b. Tim ,Year)		ic. Injury at \	_ 1	28d. Describe h	ow injury occurred		
ivision or Attendather death Director: I in by the	2 Accident Inve	estigation 28e Place of	Injury - At home, farm				Ref. Location (S	treet and Number or Ru	ral Route Number, City	
Division or spital or Attending hours after death. neral Director: After filled in by the function:		uld not be ermined (Specify)	.,,,	,, ,,			or Town, St			
Division of Vital Records, P.O. In To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be deached.  Medical Certification: To Be Completed by Ph	29a. Certifier 1 Certifying F	Physician: To the best of aminer: On the basis of ex	amination and/or inve							
To To	29b. Signature and title of certif	and manner stated ier		29c.	License nun	nber		29d. Date signed (Mo		
(A)	ling 1	no, n	) )		O.C.M.E.		1))	September 1, 20	10	
	30. Name and address of perso	n who completed cause of ant Medical Examin		Street Baltim	ore MD	21201				
State			er III Penn S	- A	OIE, IVID	£ 1£U I				
Registrar		2 2010	we S.	backel	,			<del></del>		
DHMH 17 Rev 1/2001	- 3		ORIG	INAL			0	CME		

OCME 2006

r 28a-f show notified at or be "natural", or Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23s any injury or other traumatic event, the Medical Examiner must gonee. Baltimore, Maryland 21215-0036

**Physician** 

/Medical

10a. State

MD

Director

Funeral

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Completed

Be

Examiner

**Funeral** 

Director

**Physician** /Medical Examiner

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Attending

Hospital or

the

Examiner burial-transit attending physician Physician/Medical the as nse for Completed page 2 certificate 8 2 this Certification: within 24 hours after death.

To the Funeral Director: After of the funeral pirector of the funeral completely filled in by the funeral completely filled in the funeral compl

4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 9/7/2010 Owings Mills, Md 21. Signature of Funeral Service Licenses Marchd Arrend West rak 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last ement. Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | Ho 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne: Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

Dav

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Year

State Registrar

Medical

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

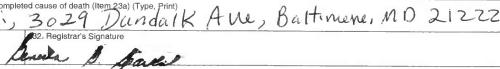
3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #788 Per FH G907 9/08/10 JH
State of Maryland / Department of Health and Mental Hygiene

			1 - State amend Registrar	#8 Per FH (	3908 1 <del>0</del> /22	tificate of	Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Reg. No. 20	10	27561
DI DI	<b>h</b> vaioi:	/	1. Decedent's Name (First, Middle, L					2. Date of Dea	ath		3. Time of Death
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j E	Examir		4a. Facility Name (if not institution, gi	Ĺ		4b. City, Town, o	or Location of Deat	th	4c. County o		
			Gilchirst Hos 5. Social Security Number 6.		" last bloth day)	Tows		- (m)		ltim	
	uneral rector				(In yrs. last birthday) 103 79 Yrs.	Months Days			,,	9. Birthpla Country	
			215-28-5497 Usual Residence of Decedent		-			07/02/	1931		DC
yland	f sho	į	10a. State 10b. County		10c. City, Town or Lo					10	d. Inside City Limits
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er de	or ite niner	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Event Armed Forces? Yes 2 N	do	Was Decedent of H If Yes, specify Cuba		pecify Yes or No- to Rican, etc.)	14. Race - Black.	- Americar , White, etc	
103(	ral", Exar	ed k	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No	Specify:		Specify:	Bla	ack
<b>21215-0036</b> within 72 hours after giene.	"natu dical	Be Completed	15. Decedent's (Specify only highest of	Education	16a. Dece	dent's Usual Occup	pation	ald a se	16b. Kind of Bus	iness Indu	ustry
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ad with	ither	3e C	Bth grade  17. Father's Name (First, Middle, Last,	na	T1	ruck Dri			Auto F	art:	s
and be file	ked o	5		,			Į.	me (First, Middle, I	Maiden Surname)		
Maryland 2 should be filed 12 th and Mental Hy	mari		Willie Harris  19a. Informant's Name/Relationship (	10h Mailie	A - June /Ctreat	Edna H		T 01-	~ ~		
M 2 sh	27 is		Melody Harris-			ng Address (Street : Solar Ci					
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	ant: If		1 Burial 2 Cremation 3 4 Donation 5 Cother (Spec	☐ Removal from State   cify)		matory or other place n Forest		1		-	ills, Md
alti grmit.	Importa any inju once.		21. Signature of Funeral Service Lines		22	Name and Addres	es of Facility			-	37.07
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			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the one cause on each line.	he death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Δ	Approximate Interval Between
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: <b>68760</b> certificate be executed nding physician and	as the	Medical		a							
χ <b>δ</b> χ certi	. use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnanc			23d. Date	of delivery	,
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UIVISION al or Attendin s after death.	by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	De Dlage of Injury	- At home, farm, stre	et, factory, office			reet and Number o	or Rural Ro	oute Number,
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DIVISION OF VITAL RECORDS, P.O. BOX 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Functal Director: After this certificate has been stoned by the attending of the Functal Director.	ted fill	Medical	(Check /2 \( \text{Medical Exam} \)	rsician: To the best of my iner: On the basis of exam	nination and/or investi	igation in my opinior	in death occurred s	at the time date and	d place, and due to	the course	a(a) and manner stated
the lithin 2	mple		only one) 3 Certifying Nur 29b. Signature and title of certifier	se Practioner: To the bes	st of my knowledge, de	eath occurred at the	time, date and pla	ice, and due to the	cause(s) and manne	er as stated	ed.
_ \ \ \ \ \ \	8	ľ	29b. Signature and three gazertines	Men		29c. License	number Q76	17	9d. Date signed (N		
		-				<u> </u>	2030	1) /	tusust	50	2010
		1	30. Name and address of person who	completed cause of death	h (Item 23a) (Type, Pr	int)	~ (1.	206.	C. 4.	The of	2010 50N M)
	State	3	31. DSEP (D-2. 201(A)	32. Registra 's	Signa ure	6/01/	NOV	orns	7(	200	4010 1049
Re	gistra		J /	Marie Common Com	See that Mary						

		١.	For State		State	e of M	aryland	d / Depa	artment of	Health and	l Mental Hy	giene 0	10	27562
			Registrar  1. Decedent's Name	(First Middle	l ast)	Certificate of Death			2 Date of De	Reg. No.  2. Date of Death  3. Time of Death				
	Physicia Medic	al	Elsie			Hele	ena		Hicks		A Wonth St	wgust 29 20		04:39AM
	) Examin	er		HOSPÌ	Tal of	1 of Baltimore			4b. City, Town, or Location of Death  Baltimore  If Under 1 Year   If Under 24 Hrs.   8		city		4c. County of Death	
	Funeral Director		5. Social Security Nu 216-30-6	617	6. Sex 1  M 2  X		e (In yrs. las 77	st birthday) Yrs.	Months Days	Hours Mir		4 Year) 33		hplace (State or Foreign Intry) MD
	cian: The law requires the ertificate has been signec ector, page 2 should be de	to	Usual Residence of 10a. State	10b. County			10c. City,	, Town or Loc						10d. Inside City Limits
21215-0036		Director	MD NA					Baltimore				1X Yes 2 ☐ No		
			10e. Street and Number					10f. Zip Code				10g. Citizen of		
		Funeral	2005 Baker Street  11. Marital Status 12. Was Decedent Ever in U					U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or				U • S • A •  14. Race - American Indian,		
		Completed by F	1 X Never Married 2 Married 3 Widowed 4 Divorced  Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.				If Yes, specify Cuban, Mexican, Puerto Rica				Black, White, etc.  Specify: Black			
15-(		nplet	15. Decedent's Education (Specify only highest grade completed)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business Industry Baltimore City		
212			Elementary/Seconday (0-12) College (1-4 or 5+) 2 yrs					Para				Public Schools_		
		To Be	17. Father's Name (F		,					Į.	ame (First, Middle		ne)	
Maryland			Hally J. Hicks St.								NILSON I Route Number, City or Town, State, Zip Code)			
			Valerie			ahtei	r		-		, Balti	-		21215
ore,			20a. Method of Disp	osition	3 ☐ Removal fi		20b. Pla	ace of Dispos	sition (Name of natory or other pla	ce)	Date	20c. Location	- City or	
Baltimore,			4 Donation	5 Other (S	pecify)	a diameter	Arl				k 9/3/2	OlO Ar	but	us, Md
Ba		8	21. Signature of Jun	la-/1	Jacob	<u></u>		14		<u>oash Av</u>	e, Balt		Md	21215
		Examiner		t failure. List c	complications the nly one cause or			. Do not ente	r the mode of dyir	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
€			Immediate Cause (Final disease or condition resulting in death)  ASUSTOL  Due to (or as a consequence of):								Onset and Death 30 minuks			
and a			Sequentially list cor	nditions	Obstructive sleep apple									years
			cause (Disease or i	Lue	Due to (ur as a consequence of).  Obesitu								unknown	
		Еха	that initiated events resulting in death) L	c. Due	c. Due to (or as a consequence of):									
09		Completed by Physician/Medical			d									
687			IF FEMALE:	prognant	23c. If yes,	outcome	of pregnan	icy				224 [	ate of del	ivon
, Box 68760			23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnance 1 Live Birth 2 Fetal d 4 Pregnant at time of dea					death 3 🔲 Ectopic pregnancy					lonth	Day Year
ls, P.O.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Type 2 DIABETES									23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown		
corc		plet	OSTEOMYELITIS								24a. Was an autopsy findings available prior to completion of cause of			
Re											perf 1 🗌 Yes	performed? death? 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 🛣 No		
/ita		o Be	25. Was case referre examiner? 1 ☐ Yes 2 🔀		Hospital:	<b>V</b> 1	0 🗆 5	D/0: tti	Ott	Place of Death (Ch				
Division of Vital Records,		Medical Certificate: To	27. Manner of Death		28a. D	ate of inju	ry 2	R/Outpatien 28b. Time of injury	28c. Inju	ry at	Home 5 Res 28d. Describe	how injury occu		(Ty)
			2 Accident 3 Suicide	5 ☐ Pendin Investig 6 ☐ Could	gation			M 1 🗆	Yes 2 No					
)ivis			4  Homicide	determ	inad   28e. Pl	e. Place of Injury - At home, farm, building, etc. (Specify)		ne, farm, stre	treet, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
_			29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										cause(s) and manner stated.	
			29b. Signature and title of certifier  MD						29c. Licens	se number		29d. Date signed (Month, Day, Year) August 29 2010		
	•		30. Name and addre	ss of person v	who completed o	ause of d	eath (Item 2	23a) (Type, P	SPITAL	OF B				
	Stat		ANA B. ENIWAND, MD SINAI HOSPITAL OF BALTINORE  31. Date filed (Month, Day, Year)  SEP 0 2 2010  32. Registrar's Signature  3. January  3. January											
	Registra		SEP U 2 2010 Charact B. garden											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2010  $A^{M}$ 7:00 Paula Hughes August 28. Maria Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House <u>Anne Arundel</u> Harwood If Under 24 Hrs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 Months (Month, Day, Yea Country) Director 275-56-9164 1956 Sept Ohio Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 407 Woodhill Drive 21117 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1X Never Married 2 ☐ Married Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes Give 1 ☐ Yes 2 🔀 No Specify: Specify: African-American Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Property Manager/Customer Svc. Highrise Apartments Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hughes, Sr. Α. Darlwyn E. Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toyette Hughes Sullivan/daughter 407 Woodhill Drive Owings Mills, Maryland 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 8/31/2010 Woodbine, Maryland ure of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, Md 21029 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician Due to (or as a consequence of): CarciNoid disease or condition M Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): sician and burial-transit executed that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospita or Attending Physician: The law requires 124 hours after decth.
Funeral Director. After this certificate has been sign 1 🗌 Yes 2**X** No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗆 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: ျှ 1 Yes 2 No HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by determined in 24 hours to the Funeral Discompleted filler Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar TIMORE MODELAS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Town, or Location of Death **Examiner** 4b. City 4c. County of Death neake hesa 8. Date of Birth (Month, Day Year 9. Birthplace (State or Foreign **Funeral** Months Country) **Director** 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify. 3 - Widowed 4 - Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 25 and Mental Hygiene. y/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ပ Informant's Name/Relationship Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name o 2 Cremation 3 Removal from State 2010 (Specify) ignature of Funeral Se 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) metastatic Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Dav Pregnant at time of death Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ျ 1 🗌 Yes 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Matural injury 5 Pending Investigation Accident after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ///annan, D69 Soma

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year,

SEP 0 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SONIA MANNAN, MD 500 UPPER CHETAPEAKE DRIVE, BEL AIR, MD

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ alo AM 2010 <u>ə5</u> JEOVER Medical 4a. Facility Name (if rich institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** estmins arrol 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Min. Year) Country) Hours 73 -38-12 Director 1939 Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No -inksburg 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral "natural", or items 23a USA Shreeve 2036 Was Decedent Ever in U.S. Armed Forces? UN 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify If Yes Give Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 13 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19a. Informant's Name/Relationship (Type, Print) hura bar bara Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State **Date UNK** 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) cemetery, crematory or other place) any injury or tro 22. Name and Address of Fricility . Signature of uneral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate 23a. Part Interval Between Onset and Death Immediate Cause (Final Physician/ ancreatiL MEGIS disease or condition Medical resulting in death) Due to (or as a onsequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and To the Funeral director, page 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 🛮 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Z No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 🗌 Yes Certificate: To 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work' 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 = Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Datę signed (Month, Day, Year) 29b. Signature and title of certifie 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2-1048 Koviits 31. Date filed (Month 0 2 2010 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6:45 P Gavin Reece Jacobs August 26, Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/A 3940 Hickory Avenue Baltimore 3 8 1 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) April 13, 2002 **Funeral** Months Days Hours Min 1**X** X M 2 □ F 217-63-4434 8 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f show 10a. State filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at Directo 1XX Yes 2□ No Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21211 Funeral 3940 Hickory Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces?

1 Yes XX No
If Yes, Give 1XX Never Married 2 Married by Specify: White 1 ☐ Yes 2/1X No Specify Baltimore, Maryland 21215-0036 3 🗌 Widowed 4 🔲 Divorced Year or Dates. Completed 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the M-dical (Give kind of work done during most of working life. DO NOT use retired) N/A College (1-4 or 5+) Elementary/Seconday (0-12) N/A 2nd18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Jennifer Anne Strubin Jason Brady Jacobs ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto, MD 21211 Jennifer Jacobs (Mother) 3940 Hickory Avenue 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkville, MD 8/31/2010 Moreland Memorial 22. Name and Address of Facility 31 Fauls was Ralto, MD 21211 21. Signature of un-Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiorespirator Physician/ disease or condition resulting in death) 5 minutes Medical Due to (or as a consequence of): Examiner Medulloblastoma Sequentially list conditions, Due to (or se a consequence of) Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No detached Unknown the a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed by 2 No 3 Probably 4 Unknown should be 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has perforr page 2 2 No 1 Tes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Division of Vital ector. Be Other: 4 \(\sum\_{\text{Nursing Home}}\) 4 \(\sum\_{\text{Nursing Home}}\) 5 \(\mathbf{X}\) Residence 6 \(\sum\_{\text{Other}}\) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 No မ 1 Yes this 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death funeral Certificate: within 24 hours after death. To the Funeral Director: After injury work 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

To the Hospital 2

ohrs State

29a. Certifier (Check

29b. Signature and title of certifier

MD, MHS both

29c. License number D0058544

Bathmore, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hopkins

2010

Waltest. Hospital 600

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#7perFH.G907.9/2/2010 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Physician/ Year 20/0 JULIAN M JONES Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death BALTIMORE UNIVERSITY BALTIMOLE OF MARY LAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign Funeral 216-85-0816 1 □ M 2 💆 F Months Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore MD1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21229 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗫 o Specify: If Yes, Give Year or Dates. Black "natural", 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' conday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname ٥ MD 21229 bourne Kd more 20b. Place of Disposition (Name or matery, crematory or other place) Method of Disposition Date □ urial 2 □ Cremation 3 □ Removal from State Windsor N.II, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen any 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANDUA SENSI Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PELITONIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of: END STAGE for use as the burial-transit RENAL the Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): RENAL Physician/Medical AGENESIS 3 405 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 2 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LUNE DISEASE 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an PULMONARY HYPOPLASIA page 2 autopsy performed? Yes 2 K No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: Other: ၉ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) iniury 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and ≱tle of certifier 29c. License number 29d. Date signed (Month, Day, Year) HO WH D7001 30. Name and address of pe rson who completed cause of death (Item 23a) (Type, Print) 2120 KERLIE A. PINKNEY 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ bert 40 AM 201 Medical 4a. Facility Name (if not institution, give street and number, of Death Examiner Baltimore 2402 Baltimore 21214 termosa (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Funeral Days Hours Months Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ **(**es 2 ☐ No more 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces?
Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working ife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Be 17. Father 's Name (First, Middle, Last မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funer Ser ce Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode Approximate shock, or heart failure. List only one cause of Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) the page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy Yes 2 W No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 7 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

**2** 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Emma Jeniter 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death muere more 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) to 5 1930 1 M 2 X F Months Hours Min. Director Usual Residence of Decedent , or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits any Injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA Loag Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade ducato Be 18. Mother's Name (First, Middle, Maiden Surname) ( wn & 17. Father's Name (First, Middle, Last) ပ Berner Elizabeth 19a. Informant's Name/Relationship (Type, Print) Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brushwood Drive Owings Mills MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Baltimone, MD Greenmount Crematan 7 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Vaugnn C. Green & Funeral Services 8728 Liberty Randallstown MD 21133 Koad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a rdiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca Physician/ disease or condition resulting in death) oncemia Medical Due to or as a consequence of): Examiner umonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq cancer 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{No} \) 24a. Was an autopsy Director; After this certificate 2 1 completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 **N**o ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) poleted cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month рм AUG 2010 28 JAMETRIS DION Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GWYNN OAK 3618 TELMAR RD. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Days Min (Month, Day, Year) 1XXM 2 - F Yrs. Director 237.69.8297 AUG. 26. Usual Residence of Decedent show Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 XX Yes 2 No DUPLIN WALLACE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 1032 N.E. RAILROAD ST. 28466 USA . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XX Never Married 2 Married 1 Yes : 2 **X** X No Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 **BLACK** 1 ☐ Yes 2XX No Specify Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 STUDENT COLLEGE 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ MARIA ANTOINETTE SMITH JEROME JACOBS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GRANDMOTHER 1032 N.E. RAILROAD ST., WALLACE, NC MRS. MARGARET SMITH Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XXBurial 2 Cremation 3 XXRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) DUPLIN MEMORIAL SEP. 4, 2010 WALLACE, NC of Funeral Service P. Name and Address of Facility FINK FUNERAL HOME, P.A. C. CGRECORY 426 CRAIN HWY. S., GLEN BURNIE FINK M01148 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 1. Enter Approximate shock, or hear failure nly one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or dillion resulting in death) Physician/ Medical a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 | Yes 2 | g | Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy perform 1 ☐ Yes 2 XNo 1 ☐ Yes 2 X No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner?
1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28d. Describe how injury occurred Suicide Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 1 Natural 5 Pending injury 28f. Location (Street and Number or Flural Boute Number, City or Town, State) 3613 Telmon Rd 4:25 PM Augus 7:2 3 2010 4:25 PM 1 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes 2 No Investigation Accident 24 hours after death Funeral Director: 6 Could not be 3 Suicide 4 Homicide determined Hom e 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check within 2 To the I only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 39. Name and address of person who completed cause of death (Nem 23a) (Type, Print) TrimbleH 0

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 2 2010

207

32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARIE THERESA JAKUBOWSKI Day 2010 August 31 2:05 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brightview Senior Living Catonsville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Oct 11. 1916 215-05-1742 1 □ M 2 😿 Months Days Hours Min Director 93 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Baltimore 1 Tes 2 X No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 133 West Meadow Road USA "natural", or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black. White, etc 1 Never Married 2 Married Completed by 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Continental Can Co. Payroll Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Thomas Anna Theresa Toth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Marx (Daughter) 513 Academy Road, Baltimore, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite injury or 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 9/4/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euperal Service Licensee Kevin E Foker McCully-Polyniak Funeral Home, P.A. 22. Name and Address of Facility 237 E. Patapsco Ave., Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, esti disease or condition resulting in death) On Medical Due to (or as a o **Examiner** Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 2 No ed by the a g 🗌 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform certificate within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 🕊 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, Seath occ d at the time, date and place, and due to the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0303 01C ted cause of death (Item 23a) (Type, Print) tolky Rd Ste 205 Catominile MD 21228

DHMH 17 Rev 7/2009

State

Registrar

SEP 0 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2:05 PM Use ph D. Keeley Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death N/A Social Security Number -1timor Medical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral Age (In vrs. last birthday) 1 M 2 □ F Days Hours 217 20 7575 84 February Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or hother traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Federal Hill 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1643 Belt Street 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Sorter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William J. Keeley Doris Μ. Crowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Ann Keeley (Sister) 1643 Belt Street, Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Sept. 3, 2010 | Baltimore, Maryland 21. Signature of Fu and Survice Licens 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between nprediate Cause (Final Onset and Death Pnysician/ Subarachnoid Medical resulting in death) Due to (or as a consequence of): **Examiner** boluval Sequentially list conditions, it may be along to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last stroke Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Feed 3—1
☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires Atrial Forillation Vital Records, No 3 ☐ Probably 4 ☐ Unknown Stage Renal Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 D No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 04 drus MD 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 30, St. Pa 21212 Registrar's Signa SEP 0 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Mary Josephine Keys 30,2010 6:48 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Aug. 11 1938 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Hours 1 🗆 M 2 🔀 F Country) Director 220-36-0043 72 Aug. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Baltimore Cockeysville 10e. Street and Number 10g. Citizen of What Country? Funeral 35 Silver Fox Ct. 21030 USA death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, . Or 1 X Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Gorman Keys Alexandra Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion W. Keys/brother 1A Dellwood Ct., Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holy Redeemer Cemetery 9/3/10 Baltimore, MD Signature of Funoral Service 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 Michael J. 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) neumonia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 4 Pregnant : 9 Unknown Yes 2 🗌 No ed by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director, After this certified completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 မ ER/Outpatient 3 DOA 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Pavillion 35 Gosnell 31. Date filed (Month, Day, Year) State SEP U 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohn Lemon, Jr.		State of Maryland / Department of Health and Mental Hygiene 1- For State  Certificate of Death  Reg. No.
Physici		1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year
Medical Exami	ner	John Lemon Je  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
		Sinai Hospital Baltimore AA
Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  444  Yrs.  If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY)  9. Birthplace (State or Foreign Country)  Months Days Hours Min.  Country)  Country)  Mayland
any		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location 10d, Inside City Limits
<b>*</b> .	ō	MARYLAND N/A BALTIMORE 1 X Yes 2 No
with the Maryland is 23a or 28a-f she e notified at once	Director	10e. Street and Number 10g. Citizen of What Country?  2574 WEST BALTIMORE Street 2/229 USA
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent Ever in U.S. 16. Race American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Was Decedent Ever in U.S. 18. Race American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Race American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Race American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Race American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Race American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
urs afte ntural", amine	Š	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done  16b. Kind of Business/Industry
036 ithin 72 ho ne. r than "na Tedical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12th  College (1-4 or 5+)  Locase Keeping  College (1-4 or 5+)  College (1-4 or 5+)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
212'	To Be	John Lemon SR  19a. Infogmant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229
and and mati		John Lemon SR (father) 2574 West BAHIMORE Street BAHIMORE MID
# # # # # # # # # # # # # # # # # # #		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, grematory or other place)  20c. Location - City or Town, State (Company)  20c. Location - Cit
Baltimore permit. Pages 1 a Department of He Important: If it in jury or other t		4 Donation 5 Other Specify:  21 Fignature of Funeral Service Licensee  22. Name and Address of Facility Inc. In. WATIACE Funeral Service
	s . Js	Naucil M. Thelace 3405 W. FRANKLin Street BAHmire Manyland 2129
Physician	6 77	2 a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated
uted nd ransit	Exa	events resulting in death). Last Due to (or as a consequence of):  d.
60, te be executed ysician and burial - transit	edical	UNPENDED AMENDED
Box 68760 ne death certificate b the attending physi	- S I	IF FEMALE: 23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month Day Year  4 Pregnant at time of death 5 Ober (Specific)
Box death the atter de for u	ysic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown
P.O.	by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
ds, P.C equires that	ted	24a. Was an 24b. Were autopsy findings available
of Vital Records, ng Physician: The law requir Mer this certificate has been s nneral director, page 2 should t	Completed	autopsy prior to completion of cause of performed?
of Vital Recing Physician: The After this certificate funeral director, page		25. Was case referred to medical 26.Place of Death (Check only one)
Vita hysicia this ce	To Be	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nursing Home 5 Residence 6 Other:
<b>~</b> ∰ , `⊄	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  1 Netural 1 Nestigation Investigation Investigation Pending 2 Nestigation Investigation I
Division tal or Attendii rs after death. al Director: A	rific	3 Suicide 6 Could not be determined (Specify) Bus Stop 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Bus Stop 28f. Location (Street and Number or Rural Route Number, City or Town, State) 260. Block of Reisterstown Road, Baltimore, MD
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	4 Momicide  29a. Certifier (Check only one)  29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To with To con	Mec	29b Signature and title of certifier 29d. Date signed (Month, Day Year)
		O.C.M.E. August 31, 2010
		30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
S	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature
Regis		SEP 0 2 2010 Server S. Saver
DHMH 17 Rev 1/2 OCME 2006	001	OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Bay. 20°10 10:10 рм MARGARET S. LAMPMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 9000 Briarcroft Lane, #111 Laurel 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Octont 2 Pay, Year 919 Days Hours 1 M 2 TX Country Wash, 579-07-6046 90 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at filed within 72 hours after death with the Maryland all Hygiene.
d other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2XXNo Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9000 Briarcroft Lane, #111 20708 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXo Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Grade 10 Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Caricofe Elizabeth Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12214 Rolling Hill Lane Bowie, Maryland 20715 Sylvia M. Covington / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 X remation 3 ☐ Removal from State W. Arundel Crematory! 9/3/2010 Odenton, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Donaldson Funeral Home, me, P.A. Laurel, Maryland M00770 313 Talbott Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebral Thrombosis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of Atrial Fibrillation years Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2XXNo Month Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4XX Unknown Completed 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of perform 2 🗓 📉 certificate 1 Yes 2 XXo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4  $\square$  Nursing Home 5 X Hesidence 6  $\square$  Other (Specify) 2XXNo မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XX Matural injury work?
1 Yes 2 No 5 Pending n 24 hours after death. e Funeral Director: Al Accident
Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifiei 1 XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29d. Date signed (Month, Day, Year) September 1, 2010 D13916 30. Name and address of person who completed cause of death (Item 23a) (Tipe, Print) Prince George Street, Laurel, Maryland 20707 M.D 321 William A. Warren,

State Registrar 31. Date filed (*Month*, *Day, Year*) **SEP 0 2 2010** 

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day 2010 Aug 29 Physician/ Vivian Anne Leonard 2:20A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner College View Center Frederick Frederick 8. Date of Birth (Month, Day, Year) 8 – 27 – 1936 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Hours Min 100-28-5625 74 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director notified Carroll MD Westminster 1 Yes X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or Funeral 90 Timber Ridge Dr. 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes No Specify: If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced Completed is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housewife 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, 2 Rosalia Solensky Ludwig Hartmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Karen Fitzgerald-daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Court St., Westminster, MD 21157 178 S. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1x Burial 2 Cremation 3 Removal from State 9-1-2010 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Westminster Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility Fletcher Funeral Home Flitchen Z honas 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph\_sician/ eas 22 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Other (specify) Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has perform 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 No 1  $\square$  Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) ၉ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? iniury 5 Pending Accident Investigation the Funeral Directory Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the P only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 232) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

10-06532 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kendrick Alexander Long, Jr. 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Kendrick Long Jr. **Medical Examiner** Alexander 1920 hrs August 29, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dundalk **Baltimore County** 7313 Berkshire Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or ff Under 1 Year If Under 24Hrs. 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Feb. 9, 1994 215-41-1593 Director Country) MD 1 X M 2 F 16 Usual Residence of Decedent 10d. Inside City Limits 'n 10a. State 10c. City, Town or Location 10b. County Dundalk show Baltimore 1 Yes 2 XNo Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygone.

part: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21222 U.S.A. 808 Mildred Avenue Funeral 14 Race - American Indian Black 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 2 X No Black If Yes, Give Year 1 Yes 2 X No specify. 4 Divorced ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dundalk High Baltimore, MD 21215-0036 Student 10th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kendrick Alexander Long Sr. Darlene R. Trentler 19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 Mildred Avenue Dundalk, Md. 21222 Trentler Darlene R. 20a. Method of Disposition 20b, Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Odenton, Maryland 9-1-2010 West Arundel Crem. Donation 5 Other Specify -22. Name and Address of Facility 21. Sign of Funeral Service Licenses Joseph N. Zannino Jr. Conkling St. Baltimore, Md.21224 PATE Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List outy one cause on each line /Medical Death Cardiac Arrhythmia Immediat Care (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Anomalous left main coronary artery Sequentially list conditions. if any leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi The law requires that the death certificate be executed Physician/Medical AMENDED 23a,b,27 per me g908 10-19-10 vt attending physician or use as the burial -X UNPENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been a ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural Director: 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide To the Hospital within 24 hours a To the Funeral I completely filled determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Che one) Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. August 30, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma			rtment of F ificate of D			ene 2010	0 27578
	Physicia		Decedent's Name (First, Middle, Las NORMA		MITCHE	LL			2. Date of Death	3¶, 20°	3. Time of Death 6:30A M
	Medic Examin		4a. Facility Name (if not institution, give GILCHRIST HOSP	street and number)	ER		4b. City, Town, or	Location of Death		4c, County of Da	LTIMORE
	Funeral Director		5. Social Security Number 6. Se 217–12–9578 1	ex	(In yrs. last birth	nday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	923	Birthplace (State or Foreign Country) MARYLAND
	ryland -f show ied at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD BAL	TIMORE	10c. City, Town	or Loca		KVILLE			10d. Inside City Limits 1 ☐ Yes 2 No
	vith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number 8800 OLD HARFO	RD ROAD			10f, Zip Code	21234	109	g. Citizen of What	
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🕅 Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ XN If Yes, Give Year or Dates.		lf	as Decedent of Hi Yes, specify Cuba □ Yes 2 🗶 No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc.
21215-0036	vithin 72 hou jiene. e <b>r than "natu</b> the Medical	Completed by	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		<u>,                                    </u>	(Give ki life. DO	NOT use retired)	ation during most of work IVE ASSI	ing	6b. Kind of Busine	es Industry  PKINS UNIV.
land 2	l be filed v fental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) OTLEY R •	MO	WBRAY			18. Mother's Nam	e (First, Middle, Mai LOUI	SE ( I	OODSON)
Maryland	d 2 should alth and M 1 27 is ma er trauma'		19a. Informant's Name/Relationship (T) FRANKLIN E。 MI			-	Address (Street a		al Route Number, Ci	-	
Baltimore,			20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		cemeter	y, crema	ition (Name of atory or other place)  CEMETI	e) ERY 9-3-		C. Location - City	
Balti	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service License	ee		22.	Name and Addres		ACH/ROS		FUNERAL HOME
	Physician/		23a. Part 1. Enter the disease, comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a Dhei	mon	les	the mode of dyin	g, such as cardiac d	or respiratory arrest		Approximate Interval Between Onset and Death
- American	Examiner	¥.		b. ———	consequence o						
	scuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate Enternation of the Cause (Disease or iinjury that initiated events resulting in death) Last	C	consequence o						
09.	ate be executed physician and the burial-transit	edical E	resulting in death, East	d							
Box 687	ith certific titending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome o  1  Live Birth 2  4  Pregnant at 9  Unknown	Fetal death		Ectopic pregnance Other (specify)	у		23d. Date of Month	delivery Day Year
ls, P.O.	uires that the dea n signed by the a uld be detached f		Part II. Other significant conditions co	ontributing to death bu	t not resulting in	n the un	derlying cause giv	ven in Part I.	23e. Did tobac	5.0	e to the cause of death?
Division of Vital Records,	The law require ate has been s page 2 should	Completed by							24a. Was an autopsy performs	prior t ed2 death	autopsy findings available to completion of cause of 1? Yes 2 🏻 No
Vital	ysician; The is certificate to director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	nt 2 🗆 ER/Ou	tpatient	Othe	ace of Death (Checier: $4 \square$ Nursing Ho	k only one) / ome 5 ☐ Residence	ce 6 Mother (Sp	pecify) AD SOCIO
on of	inding Physath. r: After this ie funeral di	Certificate: 7	27, Manner of Death 1 Natural 5 Pending 2 Accident Investigation			ime of njury	28c. Injury work M 1 🗀	/ at	28d. Describe how		
Divisi	tal or Attending P s after death. al Director: After t ed in by the funera		3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injur building, etc.	y - At home, far (Spec <i>ify)</i>	rm, stree	et, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 Medical Exami	sician: To the best of n iner: On the basis of ex- se Practioner: To the b	amination and/or	r investig	gation, in my opinio	on, death occurred a	the time, date and p	place, and due to the	ne cause(s) and manner stated.
	To the within 2 To the complete		29b. Signature and title of certifier	ner			29c. License	58303	. /	Date signed (Mo	31 2010
1			30. Name and address of person who d	completed cause of de	ath (Item 23a) (1	Type, Pr	int) INCU	unles S.	+ Tous	on mil	)
	Sta Registra		31. Date filed (Month, Day, Year) <b>SEP 0 2 2010</b>	32. Registrar	's Signature	face	v.				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ laine MACIPO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayurw Medical Center Baltimore 8. Date of Birth 05 10, 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Year 38 1 □ M 2**y**□ F 72 MD Director 217-34-3890 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State with the Maryland ral", or items 23a or 28a-f sho Examiner must be notifled at Director 1 X Yes 2 No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number Funeral 21202 U.S.A. 633 Aisquith Street "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give ...2 😾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: ₩☐ Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and P College (1-4 or 5+) Elementary/Seconday (0-12)
12th grade Telephone Company Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edith Cullerson Charles Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 60 Pacton Place , Baltimore, Md 21244 Jacqueline Hanington-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ Removal from State 9/3/2010 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) Carmel 21. Signar re Funeral Service Licenses 22. Name and Address of Facility
March F/H West Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to for as a consequence of: cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tes 1 📈 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be after death Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Eastern Avenue GIBBS MI Kevin 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 7/2009

SEP 0 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Moo Physician/ hildazi 40A Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner atonsville Haven Home xaltimove If Under 1 Year If Under 24 Hr Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 04/04/1925 1 M 2 - F Months Hours Cquotty) Lithuania Director 216-36-5592 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Halethorpe MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 United States 1115 Meadowlark Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 X No 72 hours after Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Paint Manufacturing Production Manager marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even မ Olga Budvaisite Jurgis Mildazis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1115 Meadowlark Drive, Halethorpe, Maryland 21227 Janina T. Mildazis (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 09/03/2010 4 Donation 5 Other (Specify) Loudon Park Cemetery! Baltimore, Maryland 21, Signa re of Funeral Ser 22. Name and Address of Facility Hubbard Funeral Home, 4107 Wilkens Avenue, Baltimore, Maryland 21229 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final ETHSTHIC Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner METS WITH Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) ng physician ar as the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? ρ Month Year Pregnant at time of death Yes 2 No 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 🗌 Yes 2 No 3 Probably 4. Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2/ No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 21 No Other: ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Month, Day, Year) 2859

State Registrar 31. Date filed (Month, Di

Avi, BALTO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G907, 9/27/2010, WS
State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Medical 4c. County of Death Facility Name (if not institution, give street and number City, Town, or Location of Death **Examiner** imore 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Country) Director or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director timore ☐Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 KNo Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ethtied Nurses A 15. Decedent's Education (Specify only highest grade completed) Elementary/8 congay (0-12) College (1-4 or 5+) Be Maryland Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Baltimore, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun rai Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ h disease or condition resulting in death) \_ Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed use as the burial-transit Gause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? for Month Year Day 4 Pregnant a
9 Unknown Pregnant at time of death 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ul or Attending Physician: The law requires t after death. Director: After this certificate has been sign d in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? D, ches 24a. Was an autopsy performe 1 Yes 2 No Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 NO ၉ 1 Inpatient 2 Proutpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5  $\square$  Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) pur sicion 27,2010 04202004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) murr, 250 60 Good Samaritan Hospital Baltimore, MD 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **SEP 0 2 2010** Registrar Darko

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Martinez Nidia Magali  $p_M$ 2010 7:54 August Medical 4a. Facility Name (if not institution, give street and number, Suburban Hospital 4c. County of Death
Montgomery 4b. City, Town, or Location of Death **Examiner** Bethesda Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours 219-42-1914 1 🗆 M 2 🕱 F 09/05/1927 82 Director Cuba Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Rockville MDMontgomery X☐ Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 USA 6105 Montrose Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 XYes 2 ☐ No Specify: White Cuban "natural", Specify. 3 X Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) HVAC Administrative cretary 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, L Hilberto Machado Gessa Celerina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18007 Winter Garden Terr., Olney, MD 20832 Osvaldo Martinez Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Final Journey Crem. 9/2/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO BOX 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between asteriosclerofic osdiovaxuis, Immediate Cause (Final Filysician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical The law requires that the death certificate be IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?

1 Yes 2 No Month 1 Yes 2 2 Unknown by the o. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No performed' this certificate Vital To the Hospital or Attending Physician: 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Acciden
3 Suicide 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Xevgerry Orascholinger, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

MDHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death 10 SUM If Under 1 Year | If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Min 1 ▼ M 2 □ F Months Days Hours Country) Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 21208 Koad within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Wexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ö ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Blac "natural", 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is many injury or other filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) nthia W. McNei FIMURCI 20a Method of Disposition 20b. Place of Disposition (Name of permetery, crematory or other 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Libenses Greene Funeral 22. Name and Address of Facill ughn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) on Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause E. A. Underlying Cause (Disease or linjury Due to (or as a consequence of) as the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 <a>Ectopic pregnancy</a> in the past 12 months? Day 5 Other (specify) Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Yes 2 No 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 LOWO NOSPLA Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 No Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[Insert by the cause of the cau 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d Date signed (Month, Day, Year) 29b. Signature 2010 ddress of person who completed cause of death (Item 23a) (Type, Print) M Res State

Registrar

Ament Items 25,27,28a-1 per me, good, to the Hygien [ ] 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 12:03 PM Maust 2010 Mary August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ORIEN Near If Under 24 Hrs. KWE RSIDE 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth 6/20/1908 Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1□M 2XF Days Hours 102 221-09-0142 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show ? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experiment mast be retified at 1 ☐ Yes 2 XNo Churchville Maryland Harford Director 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 21028 USA 915 Calvary Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. name: Mary Maust 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify:White Specify: \$ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Homemaker At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George William Hamby Ella Jane Swartz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Calvary Rd, Churchville, MD 21028 Sandy Bent / Great-Niece Health em 27 i permit. Pages 1 and Bepartment of Health Important: If Item 27 any injury or other troonce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Calvary Meth. Cem. 8/7/2010 Churchville 4 □ Donation 5 □ Other (Specify 22. Name and Address of Facility
Tarring-Cargo Funeral Home,
333 S. Parke St, Aberdeen, I P.A. 4D. 21001 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Carol Herenov Physician lementa disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Guston Sign Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine allive law requires that the death certificate be executed 40 sician and burial-trans Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown SUVALVY righ Completed for repair of fracture 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ₩0 certificate 1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Yes 2 T Certification: To funeral c 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28a. Date of Injury After 5 ☐ Pending investigation Subject fell 01/17/2006 1:30p. 2X Accident 1 ☐ Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Boute Number, City or Town, State) 318 W. 36th St. 4 Homicide Wilmington, Delaware Home 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) T >m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onth, Day, Y 31. Date filed ( SEP 0 1 2010 Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2110 M 2010 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL GLEN BURNIE 384 PHIRNE RD Social Security Number 7. Age (In vrs. last birthday) 24 Hrs Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F Months Hours (Month, Day, Year) JULY 14, 1942 Director 68 395.40.4236 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than """. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes XX No D00R **BRUSSELS** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2965 STEVENSON PIER RD. 54204 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2XX No Black, White, etc. δ 1 Never Married 2 XX Married 1 Yes 2 XNo Specify: If Yes Give WHITE 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) COOK **HEALTHCARE** 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P ARCHIE STRASSMAN RUTH ERSKINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD JOSEPH MALEPORT HUSBAND 2965 STEVENSON PIER RD., BRUSSELS, WI 54204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) BAYVIEW CREMATORY INC. AUG. 30, 2010 BALTIMORE, MD P. Name and Address of Facility FINK FUNERAL HOME, P.A. Service Licer GREGORY M01148 426 CRAIN HWY.S., GLEN BURNIE, MD 21061 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, he cause on each line. 23a. Part 1. shock, Enter the disease, or a heart failure. List or or com Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ALUNG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last **To the Hospital or Attending Physician:** The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: HOME 2 100 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: work?
1 Yes Natural 5 Pending 2 🗆 No Accident
Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director, /
completed filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: 1 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of cert EFENSE HIGHWAY ANNAPOLISM DZ1401 7 who completed cause of death (Item 23a) (Type, Prin

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's S

Physician /Medical Examiner Examine The law requires that the death certificate be executed

Department of Health Important; If Item 27 any Injury or other troone.

**Physician** 

/Medical

Examiner

Funeral

**Director** 

28a-f show

ural", or items 23a or 28a-f shov Examiner must be notifled at

7 is marked other than "natural", traumatic event, the Medical Exa

d 2 should be filed within the and Mental Hygiene. 7 is marked other than "". filed within 7 Hygiene.

1 and 2 s / Health a

Pages 1

72 hours after

3altimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

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the burial-trai physician Physician/Medical use as for hed by the a detached to sign be ( page within 24 hours after death

To the Funeral Director:
completely filled in by the

by

Completed

Be

မ

Certification:

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

performed? Yes 221 No

death? 1 ☐ Yes 22 No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 🔀 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

2 ER/Outpatient 3 DOA 28c. Injury at Work?

26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

RESIDENT PHYSICIAN 29c. License number RES 001 29d. Date signed (Month, Day, Year) August, 31, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED AHMED Harbor Hospital 3001 S Holnover St Baltimore 21225

State Registrar 32 Registrar's Signat

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 21:57 Roland E. McCormick August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore of last birthday) rs. las 55 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 ☐ F 10/23/54 216-68-9366 Director Usual Residence of Decedent show. 10b. County N/A 10c. City, Town or Location Baltimore permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10d. Inside City Limits 10a. State Director MD 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21206 Funeral 4400 Bowleys Lane-Apt. 3C USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status African ð 1 Never Married 2 Married 1 ☐ Yes If Yes, Give formick, Rolance Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: American 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Warehouse Elementary/Seconday (0-12) College (1-4 or 5+) Laborer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Mason O'Neil McCormick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4400 Bowleys Lane, Balt., MD 21206 (Apt.3C) Sherrill McCormick 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Balt., MD 9/4/1°0 Bayview Crematory or other place) 1 Burial 2 \*\*Cremation 3 \*\*D Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final an Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Examine the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 4 Pregnant : 9 Unknown Year Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 autopsy performe 1 Yes 2 No this certificate Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: After Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Detrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Number Practice of Tables 2 Stated (Check 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 25 2010 eted cause of death (Item 23a) (Type, Print) of Baltimore Hospital

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Prysiciant Power (Park Mark Labra) DOUGLAS W. MILLS, SR.  **April 2 Signature (Park Mark Labra) Douglas W. Mills, Signatur	Douglas W. Mills		1- For State Registrar	tate of Maryla		artment o ertificate o		nd Mental		Reg. No. 201	0 27588
SOUR STAND COURT  212-46-5492		an/	1. Decedent's Name (First, Mid DOUGLAS	W. MI		SR.			Month August 2	Day Year 8, 2010	0305 hrs
Second Security Numbers   Second Promotion   Seco			·		ımber)			or Location of De	eath	4c. County of	
21_4	Funeral				7. Age (In yrs.	. last birthday)	If Under 1 Ye	ear If Under 24	Hrs. 8. Date of B		9. Birthplace (State or
The state of the s			212-46-5492	1X M 2 F	6	3 Yrs		ys Hours I			
MD N/A BALTIMORE  107 25 Colde  108 College (1-4 or 5-1)  109 107 College (1-4 or 5-1)  100 Market Name (1-4 or 1-4 or 1-		ŀ	Usual Residence of Decedent						110/10	3/1 <u>34</u> 0 1	
Windows   A   Discrete   Proc. Circle vot   9 6 5 - 71   1   Ves   2   No. specify   Specify WILLIE   Spec	w any				10c. Cit	•					
Windows   A   Discrete   Proc. Circle vot   9 6 5 - 71   1   Ves   2   No. specify   Specify WILLIE   Spec	yland -f sho once.	ġ		N/A		BALT				40- Citi61Mb-	
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Windows   A   Discrete   Proc. Circle vot   9 6 5 - 71   1   Ves   2   No. specify   Specify WILLIE   Spec	eath v ritem	ē		Married Armed F	orces?	If Y	es, specify Cuba	an, Mexican, Pue	erto Rican, etc.)		
Physician    23a Part   Enter the disease, or complications and caused the death. Do not enter the mode of ging, such as cardiac or respersively arrest, shock, or heart failure. Let only one cause on each fire.    23a Part   Enter the disease, or complications and caused the death. Do not enter the mode of ging, such as cardiac or respersively arrest, shock, or heart failure. Let only one cause on each fire.    23a Part   Enter the disease, or complications and caused the death. Do not enter the mode of ging, such as cardiac or respersively arrest, shock, or heart	after d al", on		3 Widowed 4 D	ivorced If Yes, Give Yes	1966-	71 1	Yes 2 X N	lo specify:		Specify: V	VHITE
Physician    23a Part   Enter the disease, or complications and caused the death. Do not enter the mode of ging, such as cardiac or respersively arrest, shock, or heart failure. Let only one cause on each fire.    23a Part   Enter the disease, or complications and caused the death. Do not enter the mode of ging, such as cardiac or respersively arrest, shock, or heart failure. Let only one cause on each fire.    23a Part   Enter the disease, or complications and caused the death. Do not enter the mode of ging, such as cardiac or respersively arrest, shock, or heart	hours matur				· · ·					16b, Kind of Busi	ness/Industry
Physician    23a Part   Enter the disease, or complications and caused the death. Do not enter the mode of ging, such as cardiac or respersively arrest, shock, or heart failure. Let only one cause on each fire.    23a Part   Enter the disease, or complications and caused the death. Do not enter the mode of ging, such as cardiac or respersively arrest, shock, or heart failure. Let only one cause on each fire.    23a Part   Enter the disease, or complications and caused the death. Do not enter the mode of ging, such as cardiac or respersively arrest, shock, or heart	36 in 72 han "	Bet		) College (*	1-4 or 5+)		TADO	מים מי		TUMDE	D 00
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Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		-	mi a	J. V.	1						
Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			30. Name and address of person	n who completed caus	se of death (Iter	m 23a)					
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	-		Ling Li, MD Assist	ant Medical Exa	miner 11	1 Penn Stree		MD 21201			
Registrar SEP U I 2010 Chana S. Jakke		ate	31. Date filed (Month, Day, Year SEP U 1 201	32. Re	egistrar's Signa	ture	)				

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State of Maryland / Department of Health and Mental Hydiene

			For Amend Items 2  - State Amend Items 2	3a per dr., g90	<b>7,09/02</b> Certifi	<b>/2010di</b> icate of L	neaith and i Death	vientai Hygie	ne No.2010	0 7 7 0 0		
	D1	,	Decedent's Name (First, Middle, Las:					2. Date of Death	2010	3. Time of Death		
	Physicia Medic		Angela Neale			<u>-</u> _		August 1	Day Year 2010	8:50 PM		
)	Examin	er	4a. Facility Name (if not institution, give: University of Marylo	' ^ -		City, Town, or	Location of Death	9	4c. County of Death			
	Funeral		5. Social Security Number 6. Se	x 7. Age (In vrs. last	birthday) If	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth Cour	place (State or Foreign		
	Director		<b>219-62-0468</b> Usual Residence of Decedent	M 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Yrs.	Days	Tiodis Will.	Nov. 20	5'1954	TID		
	and show dat	tor	10a. State 10b. County	10c. City,	Town or Location	on		<del></del>		10d. Inside City Limits		
	Mary 28a-f otifie	irec	rno			mort	2			1 X Yes 2 ☐ No		
	1 and 2 should be filed within 72 hours after death with the Maryland if health and Mentell Hygiene. item 27 is marked other than "hatural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	Trance # A	1	Of. Zip Code	1229	10g	. Citizen of What Coul	A htry?		
	death Items		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was	Decedent of H	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,			
39	s after al", or Examin	d by	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1 M Yes 2 □ No If Yes, Give Year or Dates.	1 🗆	Yes 2 No	Specify:		Specify: 12	lack		
- 2	Phours "natur dical l	plete	15. Decedent's Ec (Specify only highest gra	lucation	16a. Decedent'		ation during most of work	kina 16	b. Kind of Business In	dustry		
Maryland 21215-0036	within 72 giene. ier than t, the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		OT use retired	5515ta	nt A	Lealth	Care		
ام 2	filed w al Hygi I other vent, t	Be	17. Father's Name (First, Middle, Last)	,	1-14-0			ne (First, Middle, Mai	ian Surname)	0 50. 0		
ylar	uld be Mentz narked natic e	욘	Herman E	iray			Mark	ene k	barnes			
Mar	2 should th and Me 27 is mar traumati		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing A	ddress (Street a		al Route Number, Cit acc #204	y or Town, State, Zip	Code) USI HD ZIZY4		
	1 and 2 s of Health item 27 other tra		20a. Method of Disposition		ce of Dispositio	n (Name of			c. Location - City or To			
Baltimore,	Page ment o tant: If jury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval hom otate	ho Cr	emata	N 8-2	4-10 B	altimore	MD		
Ball	permit. Page Department Important: I any injury o		21. Signature of Funeral Service License Vaushw	. Greene	722 Na Va. 515	me and Addre	of Facility Gree  More N	ne Fune	ral Service (ZIZ	vices		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									Approximate Interval Between			
P	nysician/ Medical	100	Immediate Cause (Final disease or condition resulting in death)  a. Heart ransplant Rejection  Due to (or as a consequence ):  Due to (or as a consequence ):									
	Examiner			Chronic Rejec								
_	n #	Examiner	Sequentially list conditions, litary, leading to him solute cause. Enter Underlying	Cue to (or as a nonsequer		i amuana	+hv					
	ecuted and I-trans	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequer		шуора	Lily					
0	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical		d								
68760	tificate ng ph) as the		IF FEMALE:									
	ath certifi attending for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	leath 3 🗌 Ec	topic pregnanc	;y		23d. Date of deliv Month	ery Day Year		
Ö.	that the death ned by the atte s detached for	hysi	1 Yes 2 Mo 9 Unknown	9 Unknown	000	1101 (Spearly) <u></u>						
	s that gned to be deta		Part II. Other significant conditions co	ntributing to death but not result	ing in the under	rlying cause giv	ven in Part I.		co use contribute to t			
rds	requires been sign should be	eted								bably 4 Unknown psy findings available		
eco	The law cate has t	Completed by						24a. Was an autopsy performe	prior to co death?	mpletion of cause of		
<u>a</u>	ian; IT rtificat rtor, pa	Be C	25. Was case referred to medical examiner?			26. PI	ace of Death (Chec	_	No 1 ☐ Yes	2 120 No		
<u></u>	hysica this ce al direc	욘	1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ EF			4 ☐ Nursing H		e 6 Other (Specify	<i>d</i> )		
Division of Vital Records,	nding Physician: I th. : After this certifica e funeral director, p	cate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury work M 1 🗆		28d. Describe how i	njury occurred			
VISIC	l or Attending Physician; The law after death. Director: After this certificate has I in by the funeral director, page 2 s	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, f	factory, office		28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,		
ַ ב	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the		29a. Certifier 1 Certifying Phys	ician: To the best of my knowled	lge, death occu	red at the time	, date and place, a	nd due to the cause(s	s) and manner as state	ed.		
:	To the Ho within 24 I To the Fu completed	Medical	(Check 2 Medical Examination only one) 3 Certifying Nurs	ner: On the basis of examination a e Practioner: To the best of my k	nd/or investigati	ion, in my opinion occurred at the	on, death occurred a e time, date and pla	at the time, date and p ce, and due to the ca	lace, and due to the ca ise(s) and manner as st	use(s) and manner stated. ated.		
	vit cor		29b. Signature and title of certifier	· MD		29c. License			Date signed (Month,	*		
	(8)		30. Name and address of person who c	ompleted cause of death (Item 2			80609		7	2-10		
	9		Taxya Brescia	22 South Great	ene St	reet B	altimore	MD 212	201			
	Stat Registra		31. Data filed (Month, Day, Year) SFP 0 1 2010	2. Registrar's Sign tur	park	and the second						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice of The Chesapeake Linthicm Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 02 04 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 39 Î 1 2 □ F Country) VA Months Days Hours Director 231-46**-**9712 Usual Residence of or 28a-f show filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 🗆 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 410 Wellham Ave 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Containers Corp. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Of America Forklift Operator llth grade na other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ pe David D. Owens Alice Waddy permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Owens-Wife 410 Wellham Ave, Glen Burnie, Md 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State VA cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Family Burial Site 9/7/2010 4 ☐ Donation 5 ☐ Other (Specify) Goochland, County nat revif Funeral Service Licensee 22. Name and Address of Facility
March F. H. West
4300 Wabash Ave, Baltimore, 21215 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final nset and Death Physician/ isease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year ☐ Pregnant at time of death☐ Unknown the g 🗌 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate I 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work? 2 No Investigation Could not be within 24 hours area. \_\_\_\_
To the Funeral Director. \_\_\_\_ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur and title of certifier Date signed (Month, Day, Year) 29d.

State Registrar 31. Date filed (Month, Day,

EP 0 2 2010 Jenus S. San

who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	f Maryland		artmen <i>tificate</i>			and M	lental Hy	giene	$Z \coprod \Box \Box$	27591
	Physicia		1. Decedent's Name (First, Middle, L	ast) berta	Phill:	ips					2. Date of De Month		y Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, gi Baltimore WAshi		,	enter	4b. City,		Location on Bur		<u> </u>	-4-	. County of Dea	
ı	Funeral Director		5. Social Security Number 6. 298-18-0463	Sex 1 □ M 2 ☑ F	7. Age (In yrs. Ia 9 (		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug. 1	th y Yearly	20 g. B	irthplace (State or Foreign ountry) KY
	yland -f show ed at	l. ì	Usual Residence of Decedent  10a. State  10b. County		10c. City	, Town or Loc	cation		-	-	_			10d. Inside City Limits
	th the Ma 3a or 28a t be notif	Funeral Director	Maryland Anne .  10e. Street and Number  770 209th Street	Arundel			10f. Zip	Code	211	adena 22		10g. Cit	tizen of What C	1 ☐ Yes 2 ☑ No country?
25	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	b	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Dece	2 🖾 No		Vas Decede Yes, speci		spanic Orig n, Mexican		cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi	erican Indian,
ph///	rithin 72 hours iene. r than "natur. the Medical E	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12) 1 0	Education		16a. Deced (Give k life. DO	ind of work ONOT use	( done di	uring most	of workin	ng	16b. K	ind of Business	•
Albertal Maryland 2	d be filed w Mental Hygi rked othe tic event, i	l as l	17. Father's Name (First, Middle, Las Luke Jamison	t)						er's Name Georg	(First, Middle,		Surname)	
	d 2 should alth and N 27 is ma er trauma		19a. Informant's Name/Relationship Linda Harrington		hter)		•				Route Numbe	. ,	Town, State, 2 21122	(ip Code)
Baltimore,	Page 1 an nent of He int: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		State C6	ace of Disposemetery, crem	natory or ot	her place	rch	Sept	ate . 03		er Mour	or Town, State
Balti	permit. Page 1 and Department of Hamportant: If ite any injury or of once.		21. Signatur of Euneral Service LO				. Name and	Address	s of Facilit	у	Stall	imgs		al Home, P.A.
	Physician/ Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	aused the death ch line.		r the mode	of dying	, such as (	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. Br	s as a consequ	y for	lye							yor day
09	ate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. — Due to (d	or as a conseque	ence of):			-					
Box 687	ath certific attending p for use as	š	IF FEMALE: 23b. Was decedent pregnant in the past 12 montls? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live E	come of pregnar Birth 2  Fetal aant at time of do own	death 3	Ectopic p		,				23d. Date of d	elivery Day Year
'ds, P.O.	requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	contributing to de	eath but not resu	Ilting in the u	nderlying c	ause give	en in Part I		23e. Did to			o the cause of death?  Probably 4   Unknown
Division of Vital Records,	rsician: The law re certificate has be lirector, page 2 sh	Completed							<del>-</del>				prior to death?	utopsy findings available completion of cause of
Vital	nysician iis certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:	patient 2 🗆 E	ER/Outpatien	t 3 🗆 DO	Other	ce of Deat	_		dence 6	☐ Other (Spe	cify)
ion of	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	27. Manner of Death  1  Natural 5  Pending 2  Accident Investigati 3  Suicide 6  Could not	ion	h, Day, Year)	28b. Time of injury	М			No	8d. Describe h			
Divis	tal or Att rs after d al Direct led in by:		4 Homicide determine	d 28e. Place	of Injury - At hor g, etc. (Specify)	ne, farm, stre	et, factory,	office		2	28f. Location (5 City or Tow			ural Route Number,
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	only one) 3 - Certifying Nu	miner: On the basi	s of examination	and/or investi	gation, in meath occurr	y opinior ed at the	i, death oc time, date	curred at t	the time, date a , and due to the	and place e cause(s	, and due to the a) and manner a	cause(s) and manner stated. s stated.
*	To with		29b. Signature and title of certifier	T. M	D. A	Hendu	7 29c.	License	number	_		29d. Dat	te signed (Mon	th, Day, Year)
10			30. Name and address of person who	301	Hospi	tal	Dr '	61	en l	Burr	nie, si	nD		
	Stat Registra	-	SEP 0 2 2010	32. Re	gistrar's Signatu	fark.	1				/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year larc Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Baltimore Washington Medical Center Burnie Anne Arundel If Under 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign (Month, Pay, Ye 3/26/ 1 □ M 2 🔀 F Months Days Hours Min 212-32-9384 Mary land Director 91 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Glen Burnie 1 Yes 2 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8080 Phirne Road E 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ► No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John S. Walter Emma M. Brohm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8080 Phirne RD. E Glen Burnie, Maryland 21061 <u>Mrs. Kathrvn J. Phillips</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/4/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or co shock, or heart failure. List on lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ beunen a disease or condition weak Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a cursequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 2. N 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funer. 1 Natural 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 □ Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

203 Haspital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Gary Ronald Purvis 12:38 PM st Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, pril 8. 229-34-2996 Washington, DC 77 Director **April** Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 X Yes 2 No Maryland Prince George's New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 5904 Lamont Drive 20784 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1952–1956 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced "natural" Completed Baltimore, Maryland 21215-00 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Goddard Space than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Flight Center Personnel Management Specialist Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; if item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Flossie Mayfield Kirby Clarence Otey Purvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Scott Purvis / Son 5135 Marx Drive, West River, MD 20778 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 9/3/2010 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEMIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death? certificate ha 1 Yes 2 No 2 1 No Yes 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending Safter de. eral Director: At 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 24 hours a Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar only one)

29b. Signature and title of certifier

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6510,

32. Registrar's signatur

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0050951

KENILLORTH AVE SUITE 2400 RIVERDALE MD 2073

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Helen Porohnavi August 25, 2010 2:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 2600 Erdman Avenue Baltimore 8. Date of Birth Month, Day, 12-10 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** nth Day, Year) 16 Days Months Hours 93 Director MD 214-30-4819 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shot ury or other traumatic event, the Nedical Examination to the traumatic event, the Nedical Examination MD Baltimore Baltimore Director X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2600 Erdman Avenue 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ∐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo þ Specify. Specify: White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 0 College (1-4or 5+) Homemaker Homemaker 17. Father's Name (First, Middle, Last)
Arthur Richmond 18. Mother's Name (First, Middle, Maiden Surname) Roberta Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 is
any injury or other trau Doris M. Reich Granddaughter 3800 Meghan Dr Unit C White Marsh MD21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8-31-2010 Glen Bernie MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem 22. Name and Address of Facility Simplicity Crem & Fun Thomas Allen PA 7090 Ridgerd Hanover 21. Signature of Funeral Service Licens en 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) dementia /Medical Examiner multi Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transi Exami and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? Dav Year 5 Other (specify) □Yes 2 No P.0. signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐Yes 2 ☐No 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No after death Director; d in by the f 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour. the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

MI

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Hilary Don m.D. 5901 north CHarles Street Baltmore Marylann

To the I within 2

29c. License number

D35102

29d. Date signed (Month, Day, Year)

august 27, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 27595 = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 29,2010 Ruth Ellen Pumphrey 2:59am M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore County Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 579-26-3358 1 □ M 2 🗓 F Months Hours Min (Month, Day, Year) 5/22/1925 Days **Director** 85 Wash D.C Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Owings Mills 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3420 Associated Way Bldg 3 Apt32D 21117 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married Black, White, etc. by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Census Bureau Federal Govt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H 2 Charles Buck Pumphrey Dorothy E. Payton permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17011 Troyer Rd Monkton MD 21111 Tracey M. Wise Niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Atlantic Crem 8/30/2010 Glen Bernie MD 4 Donation 5 Other (Specify) Signature <sup>22. Name and Address of Facility</sup>Simplicity Crem & Fun Ser ThomasAllenPA 7090RidgeRdHanover MD 21076 f Foreral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, COIL disease or condition ) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transil or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☑ 9 ☐ Unknown been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 은 Other (Specify) +OOICQ 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the Sest of my knowledge 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

21204

30/Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 27596 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 01, 2010 Mary Marie Rotruck 1:03 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Riverview Care Center Essex Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2XXF 10/29/1912 218-64-5027 97 West Virginia Yrs Director be filed within /2 inc....

Anntal Hygiene.

arked other than "natural", or items 23a or 28a-f snowarked other, the Medical Examiner must be notified at. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Essex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 939 Barron Avenue 21221 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes XX No Black, White, etc. ρ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes XX No Specify. Completed 3 Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other i any injury or other traumatic event, th Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Benjamin Valentine Smith Florence Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Rotruck (Son) 114 Day Coach Circle, Baltimore, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard: 09/04/2010 Baltimore, Maryland 21. Signature of Funeral Se 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. 1407 old Fastern Avenue, Essex, Maryland 21221 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) physician and the burial-transit Exam that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Day 1 Yes 2 2 Unknown ed by the a g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by Completed 0 Peneral 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica director Be 26. Place of Death (Check only one) Hospital: 2 No ုပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D212 Ohl

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Glenn Riley 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day August 28, 2010 Medical Examiner 1806 hrs Glenn Kenneth 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Country Maryland  $1 \times M$ 2 F 212-78-4906 1959 50 Nov 24 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Dundalk Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Meadow Avenue United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: White Ď 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Laborer Asphalt Company 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) portant: If item 27 is marked ury or other traumatic event, t Be Donald William Riley, Sr. Virginia Margaret Bender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia M. Riley/ mother Dundalk, Maryland 21222 715 Meadow Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Woodbine, Maryland Final Journey Crematory 9/2/2010 Donation 5 Other Specify 22 Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 ignature of Funeral Service Licenses M00957 anutal 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and Modicul Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tran Physician/Medical ttending physician a r use as the burial -UNPENDED AMENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Day Year Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۶ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural 5 Pending 1 Yes 2 No Director: in by the f Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide within 24 hours a

To the Funeral I

completely filled determined Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number August 29, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Set) Registrar's Signat State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [ ] 27598 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 27 2010 201 LORA MARY RIDGELY 6:18 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 X F Days Hours Apr. 10, Year) 1946 Maryland **Director** 64 217-50-0848 Usual Residence of Decedent traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits ~ ~ / C / M & 0 | 0 80 84 Maryland 21215-0036 Maryland Harford Abingdon 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4016 Sharilynn Drive 21009 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 XNo If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) mit. Page 1 and 2 should be filed within sartment of Health and Mental Hygiene. octant: If item 27 is marked other thai injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Daycare Provider Childcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Loren Crawford Velva Mary Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Ruth Harris / Sister 4016 Sharilynn Dr., Abingdon, Maryaland 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial Park 9-1-10 Sykesville, Maryland 22 Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition 36 hours Medical resulting in death) Due to (or as a consequence of): Examiner acidosis Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events The law requires that the death certificate be executed renal resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coaquiopathy Completed 1 Yes 2 No 3 Probably 4 Unknown Circhosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an fibrill ation Atrial performed' 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Kinpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0065421 August, 27, 2010 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive, Bel Air, MD 21014 Fistler, Christa 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 2 2010 Registrar

07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cer	tificate of	Death		R	eg. No.	
Physicia Medical Examin	n/	Decedent's Name (First, Midd Gary	dle,Last)	Smi	th			2. Date of Dea Month August 28	Day Year	3. Time of Death 2234 hrs
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death University Hospital  Baltimore				4c. County of Death	n				
Funeral Director		5. Social Security Number Ukn	6. Sex 7.	Age (In yrs. la	ast birthday)  8 Yrs.	If Under 1 Ye  Months Da		Min	th(MM/DD/YYYY) 9. Bin Foreig	gn
ne Maryland or 28a-f show any fied at once,	_	Usual Residence of Decedent  10a. State 10b. County  MD Ta	lbot	10c. City,	Town or Location					10d. Inside City Limits 1 Yes 2 No
the Maryla a or 28a-f	Director	10e. Street and Number 27990 Wood	s Rd.			10f. Zip Code 2168	31	1	0g. Citizen of What Cou	ntry?
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be positifed at once.	by Funeral	11. Marital Status  1 Never Married 2 N  3 Widowed 4 X Di	12. Was Deced Armed Force 1 Yes vorced or Dates:		If Y∈		an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race - Amer White, etc. Specify: Whi	ican Indian, Black,
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. i: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	Completed b	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12th		or 5+)		st of working lif	ation (Give kind e. DO NOT use ogist		Marine S Contract	Science
ore, MD 21215-0036 es 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than ther traumatic event, the Medica	Be	17. Father's Name (First, Middle Joseph Fre	derick Sm	ith			Ruth	ame (First, Middle, Meely	7	
e, MD 2. Land 2 should Health and M item 27 is ma	٩	19a. Informant's Name/Relation: Amy Kenyon/		Loo. 5	59820	Elkho	orn Dr	Clark,	nber, City or Town, State	
Baltimore, permit. Pages I an Department of Hea Important: If iter		20a. Method of Disposition  1 Burial 2 Crematio  4 Donation 5 Other S	pecify:	State C	Place of Disposi crematory or oth nal Jo	er place) urney	8,		20c. Location - City or Woodbine	, MD
		21. Signature of Funeral Service 23a Part I. Enter the disease of	nomas	do de de ath	270	0 Edmo	ondson	narisse Ave. Ba	N. Woods	F/S 21223
Physician Vedical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line.	of Torso		o mode or dy mig	, odor do odralo	io or respiratory and	ost, or hour	Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a co	nsequence of	·):					
ecuted and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of	·):					
760, ficate be executed g physician and the burial - transi	/Medical	UNPENDED  IF FEMALE:	X AMENDED #1	9b, per	FH,G907	,9/2/20	10,WS		23d. Date of delivery	
Box 687 e death certific. the attending p ed for use as th	Physician/	23b. Was decedent pregnant in t past 12 months?	1 Tive Ditti	t at time of dea	oth =	al death 3 er (Specify)	Ectopic pre	gnancy	Month [	Day Year
ries that the signed by the lee detached	≥∣	Part II. Other significant condi	tions contributing to de	eath but not re	esulting in the ur	nderlying cause	given in Part I.		obacco use contribute to	
Division of Vital Records, P.O. Box 68 note the Hospital or Attending Physician: The law requires that the death certifully to the Funeral Treetor: After this certificate has been signed by the attending completely filled in by, the funeral director, page 2 should be detached for use as	Completed							24a. Was a autop perfor	sy prior to death?	topsy findings available completion of cause of
cian:	å	25. Was case referred to medica examiner?					e of Death (Che			
examiner?  1 Ves 2 No    No   Hospital:   Impatient 2   ER/Outpatient 3 DOA   Other   Nursing							Residence 6 Other	-		
Division Hospital or Attent 24 hours after death tely filled in by the	Certification:	3 Suicide 6 Cou	id not be	f Injury - At ho Single Fam	me, farm, stree	t, factory, office	building, etc.		Street and Number or Ru tate) Road , Easton, MD	ral Route Number, City
To the Hos within 24 h To the Fun completely	Medical	( Cite City		xamination an					e(s) and manner as state and place, and due to th	
	Me	29b Signature and title of certific	aw)	-		29c. Licen O.C	se number		29d. Date signed (Mol August 29, 2010	nth, Day, Year)
			ssistant Medical E	Examiner	111 Penn	Street, Balti	more, MD 2	1201		
Sta Registr	te	31. DSEP 0°2, 2010"	32. Regis	trar's Signatur		-				

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RUTH **EMMA** STERNER AUGUST 26 20°10 11:25P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **BALTIMORE Examiner** CATONSVILLE CATONSVILLE COMMONS FACILITY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 😿 F 87 1 10 - 1923 215-12-9291 MARYLAND **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director BROOKLYN MD ANNE ARUNDEL 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 18th AVENUE 21225 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: WHITE 3X Widowed 4 □ Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) JOHN HOPKINS and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) MEDICAL SECRETARY HOSPITAL 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ **GEORGE** (KOPPELMAN) RAAB ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA MCHUGH/DAUGHTER 6201 CRAIGMONT RD CATONSVILLE, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) CEDAR HILL CEMETERY 8-31-10 BROOKLYN, MD 22. Name and Address of Facility CVACH / ROSEDALE 1211 CHESACO AVE ROSEDALE, FUNERAL HOME MD 21237 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. for Or danying Cause (Disease or iinjury Examine Due to (or as a consequence of) vsician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No for Pregnant at time of death Month Day Year signed by the a d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed plnous been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 N 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation after death the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

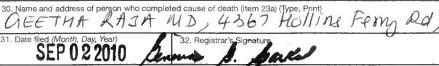
Medical Examiner: On the basis of examination and/or investigation in a second Medical 29a. Certifier

State Registrar

filed (Month, Day, Year) SEP 0 2 2010

Cicetora

(Check only one 29b. Signature and title of certification



Layor MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, License number 8754

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2010 Cathy Seeney <u>5:40a</u> <sup>™</sup> 08 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore <u>Joseph Richey Hospice</u> 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖳 F Months Davs Hours Min. O Z Z Year) Country) Director MD 214-50-7344 Usual Residence of Decedent 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director 1 ¥ Yes 2 ☐ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 U.S.A. .649 Vincent Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔏 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natura!", Black 3 Nidowed 4 X Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natur ury or other traumatic event, the Medical I ury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) loth grade Unemployed Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Catherine Sollers William Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Randall-Sister
20a. Method of Disposition Md 21244 8306 Charmel Drive, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 9/2/2010 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, al Baltimore, Md 21215 34 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Dhuse Physician Alcoholism disease or condition resulting in death) Medical Due to (o as a consequence of): un know Examine Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of, certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical n e ことにいる。 Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Year 4 Pregnant a Dav Pregnant at time of death 2 No 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy Hospital or Attending Physician: The Yes 2 1 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Certificate: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural injury work? 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 0603 any eted cause of death (Item 23a) (Type, Print) 30. Name and address of per \$12Hd Bivel a Li M)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Dededent's Name (First, Middle, Last) 2 Date of Death Month Au C Physician/ ANDALL STRICKLAND 7-10 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sanctuary at Holy Cross Burtonsville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 NC **Funeral** 1 **XX**M 2 □ F Days Hours 93 Yrs. Director 241-12-0171 NC Usual Residence of Decedent or 28a-f show 10a. State 10c, City, Town or Location Director 10d. Inside City Limits must be notified at NC Johnston Smithfield 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other thor "any injury or other traumous". or items 23a 2103 Michael Lane 27577 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc ₫ 1 Never Married 2 Married 1 Yes 2XXNo Completed 3 Midowed 4 ☐ Divorced Specify: white Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Service Station Operator Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ransom Bennett Ida West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Cooperman / Daughter 13050 Deanmar Dr., Highland, 20b. Place of Disposition (Name of Hiffs of The Neuse 20a. Method of Disposition Date August 20c. Location - City or Town, State ¥¥Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Memory Gardens 2010 Smithfield, NC Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. . Kein Skiles M01053 313 Talbott Ave., Laurel,MD 20707 23a. Fur 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAK DISEASE Physician/ ATHEROSCLEROTIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **□** No Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4: Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: ompleted filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature/and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

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30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

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2835

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32. Registrar's S

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SMITH AVE, SUITE 23.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death August 29. 2010 Physician/ Shirley Mae Smith 7:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number Funeral 1 M 2 XX Days Hours 213-20-9988 Director June 10, 1925 MD Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1XX Yes 2 No Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral U.S.A. 21211 3838 Roland Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give XX
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2√√ No Specify: 3 ₩ Widowed 4 Divorced Specify White Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Secretary 12th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norris Fiol ပ Martha Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29, 904 E. Joppa Rd. Towson, MD 21286 David Smith (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 9/2/2010 Baltimore, MD Woodlawn Cemetery 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, I
Road Balto, MD 21211 Signature of Funeral Service Ligensee 23a. Part 1. Enter the diseas , or com. lin tions that caused shock, or heart failure. List only one cause on each line or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Vear Pregnant at time of death 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2X 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗆 Yes Other: 2 X No မ 1 Inpatient 2 IER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 K Other (Specify) HOSPICE completed filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending work? 1 Yes 2 🗌 No n 24 hours after death Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within To the 29b. Signature and title 29d. Date signed (Month, Day, Year) on who completed cause of death (Item 23a) (Type, Print) 30. Name and addr

DHMH 17 Rev 7/2009

State Registrar **JACKIE** 

**JONES** 

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7:40

2010

AUGUST

SMITH

SHIRLEY

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH G907 9/02/10 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical Name (if not institution, give street and number Town, or Location of Death **Examiner** . Age (In vrs. last birthday) If Under 8. Date of Birth Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** 1 M 2 SF 86 Director 1923 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10h County 10c, City, Town or Location 10d. Inside City Limits Director Finksburg MD Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3323 Old Westminster Pike 21048 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural". Specify: White Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Coombs Rose Davis 21048 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2323 Old Westminster Pike, Finksburg, MD Frederick L. Study-husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 9/1/10 Winfield.MD 22. Name and Address of Facility Fletcher Funeral Home Signature d'uneral Service Ligensee homas <u>Main St., Westminster, MD</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death RENTI THILURY Ph sician/ HOUTE 3 Gara disease or condition Medical resulting in death) **Examiner** CARCINDUA RIGHT Kidney 2 Month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 morths?

1 Yes 2 No 23d. Date of delivery Live Birth 2 L retail 300.

Pregnant at time of death Dav Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ mais pm sighlom 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Was a autopsy performed? 2 🗌 No Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 ₩ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending Accident
Suicide 2 🗌 No Investigation neral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Godin E MS D31660 8 30 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 261

32. Registrar's Signature

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WANI MG 21030

K. GALVINITIMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per verb., g907,09/02/2010dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stancil 9-26 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death mor last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Date (Month, Months Days Hours Min. Yrs Director and Mental Hygiene.
'is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Tes 2 No 2000 Street and Number 10f Zip Code 10g. Citizen of What Country? Moinger 11 Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 ☐ Married Yes 2 No 1 Yes 2 No Specify: If Yes, Give Year or Dates. 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working \_\_\_\_\_\_ife.DQ NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) econday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Plint MOHOS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service icensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition Hepatic CIVVLOSIS courter Medical resulting in death) Due to (or as a consequence of): Examiner patitis years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? insufficiency 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2. autopsy perform 2 No 2 1 Yes ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: ဂ္ 2 No Hospice 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Accident s after death | Director: / by the 1 Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined completed filled in 24 hours a Funeral I Medical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Cartifying Nurse Practioner: To the best of my knowledge, deeth accumd at the time date and plan unity one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 00070635 26/10

State Registrar .64.

Bultimore, MD

21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Patel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Washington, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X**-X<sup>M</sup> Director 76 251-52-0259 03 - 27 - 1934Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5210 Ready Ave. 21212 IISA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc by 1 Never Married 2 Married Yes 2 XXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify. Specify: Black ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Repairing Homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Washington Sr. Helen Simmons Louis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cemetery, crematory or other place,

New Mt.

M01452

Physician/ Medical Examiner

attending physician a for use as the burial-

signed by the a

certificate has been si rector, page 2 should l

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran:

Jervy Washington / Son

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

hal ai

1XXBurial 2 ☐ Cremation 3 ☐ Removal from State

20a. Method of Disposition

Immediate Cause (Final

disease or condition

resulting in death) Last

23b. Was decedent pregnant

1 Yes 2 9 Unknown

in the past 12 months?

IF FEMALE

Part II.

22. Name and Address of Facility
Bailey Funeral Home and Cremation Service, PA
4023 Annapolis Road, Halethorpe, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death

3 Ectopic pregnancy 5 Other (specify) \_\_\_

1318 French Santee Rd., Jamestown, SC 29493

Zion Cemetery 09/06/2010 Jamestown, SC

Exami Physician/Medical Completed by Be မ 27 Certificate:

Medical

Other significa	int conditions contributing to death but not re	esulting in the ur	nderlying cause given in Part I.
HUMAN	IMMUNODEFICIENCY	VIRUS	INFECTION

9 Unknown

Pregnant at time of death

23e. Did tobacco us	e contribute to the cause of death?
1 Yes 2	No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

23d. Date of delivery

Day

Year

Month

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
1 Yes 2 No	ospital: 1 Na Inpatient 2  ER/Outpatient 3 DoA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	28a. Date of injury (Month, Day, Year)  28b. Time of Injury  M  28c. Injury at work?  1  Yes 2  No						
4 Homicide determined							

		On S	of Town, State)
29a. Certifier (Check only one)	1 Certifying Physician: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of examination and/or investigation. Certifying Nurse Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at the time	e, date and place, and due to the cause(s) and manner stated.
29b. Signature ar	and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27607 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 2010 8:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Harbor Hospital Baltimore 6. Sex 1 M 2 D F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. Hours 228-68-9530 51 Director Virginia Usual Residence of Decedent shov 10a. State 10b. County with the Maryland Ħ 10c. City. Town or Location 10d. Inside City Limits Director traumatic event, the Medical Examiner must be notified 28a-f MD 1 🗌 Yes 2 🎦 No Anne Arundel 10e Street and Numbe ä 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 109 Camrose Avenue 21225 United States items ; Page 1 and 2 should be filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ō ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural" 3 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Mechanic Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ John Lawrence Walsh Janice Owens 19a. Informant's Name/Relationship (Type, Print) Cynthia Walsh/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i other 1 109 Camrose Avenue Anne Arundel, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite cemeter, crematory or other place)
Atlantic Crematory, LLC8/28/2010 1 Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Euneral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. any Sulphur Spring Road Arbutus, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami and Due to (o attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month the 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of ate has l autopsy death? certificate 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ျှ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death funeral 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After appleted filled in by the funer 5 Pending 1 🔲 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying flurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 1 within 2.

To the F e Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month) Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of pe

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leted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Department of Health and Mental Hygiene [] for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08-3. Time of Death -26 - 2010Physician/ Month WORTHINGTON E Q . 30 DM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAMARITAN 400D HOSPI TAL BALTIMORG BALTIMORG 7. Age (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Min. 1 🗆 M 2 🗷 F Months Hours 241-32-9101 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 21212 U.SA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 ₩Widowed 4 □ Divorced "natural" Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary (Seconday (0-12) College (1-4 or 5+) 155istant permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumment. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည tred lark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Dauahter 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) BOTHMUYE, 1 4 Donation 5 Other (Specify) 1ar Signature of Funeral Service Licenses 405 Koad 22. Name and Address of Facility NO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SEIZURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CEREBROVASCULAR ACCIDENT (STROKE) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) ATRIAL FIBRILLATION resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be exec physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death the 1 ☐ Yes 2 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COLO RECTAL CANCER 1 Tes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an eral Director: After this certificate has filled in by the funeral director, page 2 s performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gentifying Number Practices 1. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practices 1. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Dav. Year) RES 006 30. Name and dress of person who completed cause of death (Item 23a) (Type, Print) 5601 BLV D, NWE LOCH RAVEN BALTIMORG ZIN 32. Registrar's Si Statu 2010

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last, 2. Date of Death Month Physician/ El 0056 2010 Medical institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death HiMore lemorio Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** 72 Yrs. 1 🗆 M 2 😿 F Min Days Director death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore 1 Yes 2 ☐ No or 28a-f 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1e VIIIe Funeral items 23a 212 1SA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō þ Yes 2 No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Menta once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 01005 ga Informant's Name/Belationship (Type, Brint ANIOTEW LEE/WALSON ST Rural Route Num 19b. Mailing Address (Street and Number of Avenue Telville 20a. Method of Disposition 0b. Place of Disposition (Name of Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician rator disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and dedetached for use as the burial-trar as a consequence of Hospital or Attending Physician: The law requires that the death certificate be exec Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has page 2 erformed' 2 🗌 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No Certificate: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🔲 only one 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) 2010 npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person Krol Inion Memoria Jonathar (Month, Day, 31. Date filed Registrar's Sign State

DHMH 17 Rev 7/2009

Registrar

2 2010

Amend #1, per MD & #11, per Fh G908 10/12/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Wilford Riley Whorton, Jr. 2 Date of Death Wilford Month **Physician** Whorfor August 2010 25, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Yrs Director 68 214-38-0223 March 6, 1942 New York Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2 ☑ No the Medical Examiner must be notified MD Baltimore Timonium 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ò or items 23a 17 Ballyhean Court 21093 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 x No Specify: 3 Widowed 4 Diversed Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Financial Advisor Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilford Riley Whorton, Sr. ည Stella Mae Rolison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret H. Henderson Partner 17 Ballyhean Court Timonium, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Carroll Cremation Ser 9/1/10 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Eline Funeral Home Reisterstown, MD Approximate Interval Between Onset and Death Immediate Cause (Final Septic shock **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner cell lenkemia Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trai Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \( \subseteq \text{Live birth} \) 2 \( \subseteq \text{Fetal death} \) 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear Pregnant at time of death 5 Other (specify) Yes 2 □ No Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has director, page 2 has performed 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 1 ☐ Yes 2 ☑No 6 Other (Specify) ၉ 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury death. 1 Yes 2 🗆 No 2 Accident a er death Director A d in by the f 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. Distine E. RES-000 August 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERRY, MD. CRISTINE 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 0 2 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5,10e perFH, G908,10/6/2010 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMonth Physician/ RAZEN # M Medical 4a Facility Name (if not institution, give street and number City, Town, or Location of Death Examiner County of Dea dica IPN BURNIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 10, 1950 Birthplace (State or Foreign Country) **Funeral** -40-8465 1**X**X M 2 □ F Hours Days Director 60 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 XX No ANNE ARUNDEL GLEN BURNIE 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 7900 BENESCH CIRCLE Funeral APT. 772 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian WALter Black, White, etc. þ 1 Never Married 2 Married Yes 2 XXVO Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify WHITE "natural", Completed 3 Widowed 4 XXDivorced Specify: Year or Dates. the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PRISON GUARD PRISON Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be WALTER JOHN WRAZEN AGNES VOYCIK WRAZEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA RAZLER Page 1 and 2 900 FALL RIDGE, CAMBRILLS, MD 21054 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 XX Burial 2 ☐ Cremation 3 XX Removal from State 4 Donation 5 Other (Species ST. MARY'S NATIVITY CEM. PLYMOUTH, PA SEP. 3, 2010 2. Name and Address of Facility FINK FUNERAL HOME, P.A. 21. Signatu 14 CRECORY FINK M01148 426 CRAIN HWY. GLEN BURNIE complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the die shock, or heart failu Approximate Interval Between one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death -p5n Physician Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury signed by the attending physician and deedecached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1  $\square$  Yes 2  $\square$  No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioners the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi and address of person who completed cause of death (Item 23a) (Type, Print) JASHING TOI MODICA

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 31 Day 2010 Pear Physician/ YOUNG DOROTHY HAYS 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Brightview Assisted Living Bel Air 8. Date of Birth (Month, Day, Year) Oct. 11, 1911 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2🛣 F Hours 213-38-6326 Director 98 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo Harford Maryland Bel Air 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Funeral 300 West Ring Factory Road 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo "natural", Specify: White 3

Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hutchinson Winfield Hays Anna Noble Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Old Orchard Road, Bel Air, Maryland, 21014 Donald H. Young / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Fallston UMC Cemetery 9/4/2010 Fallston, Maryland tura of Funeral Service, Licensee McComas Funeral Home, P.A. 22. Name and Address of Facility 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ elenen end stu Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 1 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Vear Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? this certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6X Other (Specify) Assisted Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Living work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Dan & SV 03553 DUQUST 31, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David 5 Du W. Mac Pha. / , Bel Air, Maryland 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 2 2010 Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 1 1 2 7 6 1 3 State of Maryland / Department of Health and Mental Hygiene

Carroll Hospital Center Westminster	
4a. Facility Name (if not institution, give street and number)  Carroll Hospital Center  4b. City, Town, or Location of Death  Westminster	
Carroll Hospital Center Westminster	a County of Dooth
To the state of th	c. County of Death  Carroll
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM	M/DD/YYYY) 9. Birthplace (State or Foreign
Director 216-72-4513   1XM 2 F 40 Yrs.   Months Days Hours Min. March 23,	1970 Country) Maryland
Usual Residence of Decedent	
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits  1 Yes 2xx No
The state of the s	tizen of What Country?
	J.S.A.
12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black,
11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	White, etc.
3 Widowed 4 X Divorced If Yes, Give Year or Dates:	Specify: White
15. Decedent's Education (Specify only highest grade completed) 16b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Elementary/Secondary (0-12)  College (1-4 or 5+)	Kind of Business/Industry
15. Decedent's Education (specify only highest grade completed)  16. Decedent's Sudar Occupation (sive kind of work done during most of working life. Do NoT use retired)  17. Father's Name (First Middle Last)	Electrical
E   2   Electrician	Electrical  Sumame)
Programment of the programment o	
Name/Relationship (Type, Print ) 19b. Malling Address (Street and Number or Rural Route Number, C	
Stephanie E. Moore Mother 400 Bonn Court Westminster, MD	21157 Location - City or Town, State
1 Secretarion 3 Removal from State crematory or other place)	
The state of the s	Iliamsport, MD
Magne Osterling ELINE FUNERAL HOME Reisters	
Physician 231. Part I. Ellipsi the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she failure. List who one cause on each line.	ock, or heart Approximate Interval Between Onset and
Examiner Immediate Cause (Final disease a. Oxycodone intoxication	Death
or condition resulting in death)  Due to (or as a consequence of):  b.	
b lif any leading to immediate  Due to (or as a consequence of):	
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):	
per purity resulting in death). Last d d	
d.  AMENDED	
See	d. Date of delivery
23b. Was decedent pregnant in the past 12 months?  1	Month Day Year
23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
So ye as the past 12 months?  O and the past 12 months?  O there (Specify)	use contribute to the cause of death?  No 3 Probably 4 Unknown
24a. Was an autopsy	24b. Were autopsy findings available
The law requires the control of the	prior to completion of cause of death?
To the second s	No 1 Yes 2 No
1 Ves 2 N  25. Was case referred to medical examiner?  1 Ves 2 N  1 Ves 2 N  26. Place of Death (Check only one)  1 Ves 2 N  1 Ves 3 N  1 Ves 4	ence 6 Other:
24a. Was an autopsy performed?    Types 2   No   Place of Death (Check only one)	
Very 1 1 Natural 5 Pending Investigation Fd 8/27/10 Fd 9:36 pm 1 Yes 2 No unk	
To so the first of	and Number or Rural Route Number, City 400 Born Court
determined (Specify) found at notifie (Westminst	er, MD
Company   Comp	
and manner stated.  29b. Signature and title of certifier  29c. License number  29d.	Date signed (Month, Day, Year)
O.C.M.E. Aug	gust 28, 2010
30. Name and address of person who completed cause of death (Item 23a)	
Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

			1 - State of Maryland / Department Certificate  Certificate	nt of Health and I e of Death		ene <sub>9. N</sub> 2 0 1 0	27614
			Decedent's Name (First, Middle, Last)	o or Boatin	2 Date of Dogth		3. Time of Death
	Physicia Medi		Curtis Warren Anderson		8 1	3 Day 2010 Year	1:45 P M
	Examir		4a. Facility Name (if not institution, give street and number)  4b. City	Town, or Location of Death		4c. County of Death	
-quel				isbury		Wicomico	
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	r i Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth 7 /3/1923	(ear) 9. Birth	nplace (State or Foreign ntry) VA
	100	1	Usual Residence of Decedent		17571525		
pland	f sho	횽	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Z Z	r 28a notifi	Director	MD Worcester Snow Hill  10e. Street and Number 110f 70				1 🗌 Yes 2 🕱 No
ith th	23a o st be	la I	101. 21		10	g. Citizen of What Cou	untry?
v dte	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	863 dent of Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Ameri	can Indian
وَ يَ	or if	þ	1 ☐ Never Married 2 ☐ Married	cify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
	tural' al Ex	Completed	Year or Dates.	2₺ No Specify:		Specify: wh	ite
ZIZIS-UUSO within 72 hours after	in "na Medic	lg l	iida DO MOT	rk done during most of work	ding	6b. Kind of Business Ir	ndustry
Mithin N	giene. er tha the l		Elementary/Seconday (0-12) College (1-4 or 5+) Engineer	retirea)		Engineeri	ng
E E	d oth	Be c	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Ma		
yiand	Ment narke	ြင	Curtis Warren Anderson	Fannie	e Unknown		
2 shor	h and 7 is n traum			(Street and Number or Rura			
a gr	Heall tem 2		Burton Anderson / son   9037 Mar   20a. Method of Disposition   20b. Place of Disposition (Nar	shall Creek R			
	ent of nt: If i		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State	ther place)		Oc. Location - City or T	
Dallillor permit. Page 1	Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		tape nengepen	d Address of Facility Bu		rankford, neral Home	DE
a g	22 = 8 8		11. Tilla Centrale 108 W	illiam St., E	Berlin, M	D 21811	
√Ph	sician/		23a. Pan 1. Enter the disease, or complications that daused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Coronary Artery Disea		or respiratory arrest		Approximate Interval Between Onset and Death ears
	Medical xåminer		resulting in death)  a. Due to (or as a consequence of):	30		у	cars
		er	Sequentially list conditions, if any, leading to immediate b. Dementia  Due to (or as a consequence of):			У	ears
ped	nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Linter Uniderlying Cause (Disease or iinjury				
execu	ın and ial-tr <b>a</b>	Exa	that initiated events c.  The presulting in death) Last Due to (or as a consequence of):			<del></del>	
e pe	physician and the burial-transit	dical	d				
rtifical	ing ph e as th	/Me	IF FEMALE:				
Attending Physician: The law requires that the death certificate be executed	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic p	regnancy		23d. Date of deliv	·
he de	ned by the a detached t	hysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (sp. g ☐ Unknown	эсіту)		INIOIIII	Day Year
that t	ned b e deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
quires	s been signe should be	ted t			1 ☐ Yes	2 <b>X</b> No 3 ☐ Pro	bably 4 🗆 Unknown
aw re	as be	Completed			24a. Was an autopsy		psy findings available impletion of cause of
The	page	Con			performe	d? death?	· _
ician	r this certificate ral director, pag	m	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check	( only one)		
Phys	eral di	e: 10	1 Inpatient 2 ER/Outpatient 3 DC			e 6 Other (Specify	)
nding	ath. r: Afte ie fune	icat	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation M	work? 1 \( \subseteq \text{ Yes}  2 \( \subseteq \text{ No} \)	28d. Describe how i	injury occurred	
Atte	recto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office :		t and Number or Rura	Route Number,
italo	urs af				City or Town, S	,	
To the Hospital or	within 24 hours after death.  To the Funeral Director, After completed filled in by the funer	Medical	29a. Certifier (Check Check only one)  2 Certifying Physician: To the best of my knowledge, death occurred at a model of the configuration of the properties	ov opinion, death occurred at	the time date and n	lace and due to the co	usals) and manner stated
To	To		29b. Signature and title of certifier 29c.	License number		. Date signed (Month, I	
			1/1/pein 0	2134		1/17/	
3) j	15+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins, MD 200 Civic Ave., Sa	alisbury, MD	21804	1 120	
	State Registra	e ∜ ır	31. Date filed (Month, Day, Year)  AUG 18 2010  32. Fegistrar's Signature  August				

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Adams 17 2010 06:10 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil E1kton Laurelwood Care Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 10,1914 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 ☐ F WV 96 218-01-8544 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 ☐XNo Directo Colora MD Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21917 2485 Liberty Grove Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ∏Yes 2 ∭XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 X No þ Specify: 3 XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tree Trimmer Tree Trimming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lizzie B. Wingler Thomas C. Adams ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2489 Liberty Grove Rd. Colora, MD 21917 Carl D. Adams / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 8/21/2010 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Conowingo, MD Conowingo Baptist Cemetery 4 ☐ Donation 5 ☐ Other (Specify) fignature of Funeral Service Licens 2. Name and Address of Facility
.T. Foard Funeral Home, P.A
11 S. Queen St. Rising SUn, P.A. MD 21911 111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one clude on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 No certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0026183 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) venue NorthEast, mo 21901 Dr. Madhu Sachdev d (Month, Day, Year) AUG 2 0 2010 State Registrar

DHMH 17 Rev 1/2001

			For State Registrar		State of IVI	aryland	Cer	tificate of	neaim Death	and N	лептат ну	gien Reg. N		276	16
	Physicia	in/	1. Decedent's Nam		*						2. Date of De 08/14/		ay Year	3. Time of	
	Medic Examin	cal	DELLA LO  4a. Facility Name (ii		ve street and number)			4b. City, Town, o	or Location	n of Death	08/14/		c. County of Dea	1:15	F ₩
	LXamiii				nter Fredei	rick		Frederi					rederic		
	Funeral Director	15751255	5. Social Security N 214-12-4	738	Sex 1 □ M 2 🔀 F	e (In yrs. last .90	t birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da 08/02/		g. Bir	thplace (State or nuntry) MD	Foreign
and	show	tor	Usual Residence of 10a. State	10b. County		10c. City, 1	Town or Loc	cation						10d. Inside Cit	y Limits
Mary	28a-f	Director	MD	Frederi	ck	Fred	lerick							1 XYes	2 🗌 No
th the	3a or t be n	alD	10e. Street and Nu		1			10f. Zip Code				_	Citizen of What Co	ountry?	
ath w	ems 2 r mus	Funeral	5263 Bam	burg Cou	12. Was Decedent B	Ever in U.S.	13. V	21703 Vas Decedent of F	Hispanic C	Origin? (Spe	ecify Yes or No-	USA	14. Race - Ame	erican Indian	
<b>5-0036</b> 2 hours after de	Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by		ried 2  Married	Armed Forces?	No		Vas Decedent of H Yes, specify Cub ☐ Yes 2X No			Rican, etc.)		Black, Whit		
<b>ا-د</b> ا	"natu	plet	(Spe	15. Decedent's ecify only highest			(Give k	ent's Usual Occu	during mo	ost of work	ing	16b.	Kind of Business		
/ithin /	r than	Completed	Elementary/Sec 12th	conday (0-12)	College (1-4 or 5		Beaut	o NOT use retired ician	)			Co	smetolo	TV	
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yland Jid be filed	Menta narked natic e	ျာ	James Ha						Ros	е Е.	Willian	ns			
;, Mar nd 2 shou	ealth and m 27 is n ner traum		19a. Informant's N	ylor - d				g Address (Street B <b>amburg</b>						o Code)	
<b>SAITIMOFE,</b> permit. Page 1 and	ment of H tant: If ite ury or oth		20a. Method of Dis 1 ☐ Burial 2 4 ☐ Do ation		Removal from State	cem	netely, crem nt Cr	sition (Name of patory or other pla remation	Svc	8/17		Ha	nover, N	1D	
<b>Dall</b>	Depart Import any inj once.		21. Signature of Fu	neral Service Lice	X- Lim	h		Name and Address 46 N. Wa							
Ph	ysician/	9	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition	irt failur <b>e</b> . List only (Final	implications that caused one cause on each line									Approximate Interval Betv Onset and D MONTIS	veen
	Medical xaminer		resulting in death)	í	Due to (or as a		nce of):								
		iner	Sequentially list co if any, leading to in cause. Enter Under	nmediate A	b. Due to (or as a	a consequen	nce of):								
Y no	and transit	xam	Cause (Disease or that initiated event resulting in death)	iirijury	c. Due to (or as a	a consequen	oce of:						3		
be exe	sician a	calE	resutting in death)	Last	Due to (or as a	a consequen	ice oi).								
or ou	ig phy as the	Medi	IF FEMALE:		_ d										
e death cert	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	23b. Was decedent in the past 12 1 Yes 2 [ 9 Unknown	months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a g ☐ Unknown	2 Fetal d	leath 3 L	Ectopic pregnan Other (specify)	су				23d. Date of de Month		ear
that th	ned by detac	by Ph	Part II. Other signi	ficant conditions	contributing to death b	ut not resulti	ing in the ur	nderlying cause g	iven in Par	rt I.	23e. Did to	obacco	use contribute to	the cause of de	eath?
duires	en sigi	ted k									1 🗆	Yes 2	2 □ No 3 □ P	robably 4 🛚 L	Jnknown
Records, The law require:	ate has be page 2 sho	Completed				_					24a. Was auto perfo 1  Yes	DSV	prior to	topsy findings a completion of ca s 2 \(\sime\) No	vailable ause of
VILCIII yslcian:	sertific ector,	Be	25. Was case referr examiner?		Hospital:					eath (Check					
Phys	r this o	<u>ان</u>	1 ☐ Yes 2	Xi No h	1 ☐ Inpatie	ent 2 EF	R/Outpatient	t 3 DOA Oth	4 L <b>X</b> 1		me 5 Residence 128d. Describe h		6 Other (Spec	ify)	
onding	ath. r: Afte ne fune	icate	1 🕅 Natural 2 🔲 Accident	5 Pending Investigati	(Month, Day on	v, Year)	injury	wor	k? Yes 2[	_	zod. Describe i	iow inju	ny occurred		
UIVISION OI tal or Attending PI	rs after de al Directo ed in by th	al Certificate	3 ☐ Suicide 4 ☐ Homicide	6 LJ Could not determine			e, farm, stre	et, factory, office			28f. Location (S City or Tow		nd Number or Ru e)	ral Route Numbe	er,
Hospi	24 hou Funer leted fil	Medical	(Check 2	Medical Exa	ysician: To the best of miner: On the basis of ex urse Practioner: To the	xamination ar	nd/or investi	gation, in my opini	on, death	occurred at	the time, date a	and plac	e, and due to the	cause(s) and man	ner stated.
To the	within To the	2	<del></del>	title of certifier	inse i ractioner. To the	best of my ki	nowleage, a	29c. Licens	e number		e, and due to th		ate signed (Monti		
	į		DOD					Dot	6 22	-23			8/17/10	)	
			20		completed cause of de 196 Thoma		, , , , .	,	132	Frod	lariak	MID	21702		
	Stat	te	31. Date filed (Mont		3. Registra	ar's Signature		DIIVE, #	T 3 2 %	1160	CT TOW,	עוניג	21102		
	Registra		A	IC 2 0 20	10 Bus	1 12.	Moar	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death A Worth, 17, 22010 Year  $\overset{3. \text{ Time of Death}}{2120}$ Physician/ Arthur Bischoff Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery **Examiner** 4b. City, Town, or Location of Death Montgomery General Hospital Olney Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F 86 Months Days Hours 1690271923 Swirtzerland Director none Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville MDMontgomery 1 🗆 Yes 2 🎽 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 3926 Fox Valley Drive Switzerland Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. White If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ife. DO NOT use retired) Machinist Elementary/Seconday (0-12) College (1-4 or 5+) Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gustave Bischoff Lina unk. 19a. Informant's Name/Relationship (Type, Print)
Shiela Bischoff/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3926 Fox Valley Drive Rockville, Md. 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) Chesapeake Crem. 8/19/2010 Beltsville, Md 4 Donation 5 Other (Specify) Signature PHOTE AND SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequent Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician an formeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Yes g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Thypoid 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No Yes 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 2 29c. License number Med Director 10050410 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

DHMH 17 Rev 7/2009

State Registrar chase

31. Date file

♣2. Registrar's Signature

Olney MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August-Donald Alfred Brunette 730P M 2010 Medical 4c. County of Peath 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death VA MARKAND HEALTH EARE SYSTEM POINT PERRY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec 18. **Funeral** 9. Birthplace (State or Foreign 016-14-0371 1 X M 2 D F Months Days Hours KNOWN TO PHYSICIAN BRUNETTE, DONALD Baltimore, Maryland 21215-0036 89 Director 1920 Massachusetts Usual Residence of Decedent and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f shor raumatin event, the Medical Examiner must be notified at 28a-f shov 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Cecil Rising Sun 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 100 McNamee Lane 21911 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 V Yes 2 No
If Yes, Give
Year or Dates. 1940-59 Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. 3 X Widowed 4 □ Divorced Specify Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation Port Deposit Post Office (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ten Years Mail Carrier Port Deposit, Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver Levi Brunette Louise Justi per it. Page 1 and 2 should · e
Det artment of Health and Men
Important: If item 27 is marke
any injury or other traumatic
one e. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Frieda A. Jack (daughter) 184 Codjus Drive, Rising Sun, Maryland 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ,20c. Location - City or Town, State West Chester. 1 🗆 Burial 2 🖔 Cremation 3 🗆 Removal from State R.A.Ferris & Co..Inc. 4 ☐ Donation 5 ☐ Other (Specify) 08/20/10 Penns vl vania Signature of Funeral Service License ee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ COR PULMONALE disease or condition 5 month Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Lindarlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Exam the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No After this certificate has been signed by the atte funeral director, page 2 should be detached for 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructuse Lung Disens 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed death? ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, I Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending Accident
Suicide Investigation 1 Yes 2 No 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in his opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of HW 54439 MD August 16,2010 tellucio 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) incend A giminaro Do VA MD MEDICAL CENTER - PERRY POINT. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	. 10
1 - State Registrar Certificate of Death Reg. No. 2 U   2   1   2   1   2   1   2   1   2   1   2   1   2   1   2   1   2   2	Death
1. Decedent's Name (First, Middle, Last)  Month Day Year	P <sup>M</sup>
al Roy Carter Bowman August 10 Zully 17.00	Г
4a. Facility Name (if not institution, give street and number)	
Effect of Defice in the second of the second	Foreign
5. Social Security Number 6. Sex 1. Age (Iff yis. fast bit ulday) Months Days Hours Min. (Month, Day, Year) Virginia	
Usual Residence of Decedent	v Limite
10a. State 10b. County 15th County 1178 Yes	•
Maryland Caroline Denton  100 Citizen of What Country?	
To. Street and Number	meri
120 Sunset Drive 21629 United States of A	mer r
Armed Forces?  1 Never Married 2 Married 1 Felyes 2 No 1942 If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.	
1 Never Married 2 Married 1 Specify: 1 Yes 2 No Specify: Specify: Caucasian	
	,
(Specify only highest grade completed)  (Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)  Nylon Manufacturi	ng/
5 11 HS grad Supervisor/Farmer Farming	
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
Roy Orville Bowman    Sther H. Gardner	
Grace E. Bowman Wife 120 Sunset Drive, Denton, Maryland 21629  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)	
1 Liguria 2 Cremation 3 CHemoval from State	.1
4 Donation 5 Other (Specify) Hillcrest Cemetery 8/23/2010 Federalsburg, Mary 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moore Funeral Home, P.A.	Tanc
12 South Second Street, Denton, Maryland 21	629
23a Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximat	е
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Death
disease or condition resulting in death)  Due to (or as a consequence of):	-0
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	
that initiated events C	
resulting in death) Last Due to (or as a consequence of):	
d.	
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	
23b. Was decedent pregnant in the past 12 months?    23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day	Year
1 Yes 2 No 9 Unknown	
	death?
1 Yes 2 No 3 Probably 4	Unknown
24a. Was an autopsy findings prior to completion of earth?  1  Yes 2  No  1  Yes 2  No	available
autopsy performed? prior to completion of c	ause of
25. Was case referred to medical examiner?  1   Yes   2   No.   Hospital:   Inpatient   2   ER/Outpatient   3   DOA   Other:   All Dursing Home   5   Residence   6   Other (Specify)	
Natural 5 Pending (Month, Day Year)  Accident investigation M 1 Yes 2 No	
3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	nber,
27. Manner of Death  A Natural   2   Accident   3   Suicide   4   Homicide   4	
	(s)
one) and manner stated.	
29b. Signature and title of certifier  AD  DOOLTS34  Zero. Date signed (Total), Day, Carly  DOOLTS34	`
	<u> </u>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Wafik Zaki, M.D., 920 Market Street, Denton, Maryland 21629	
Wallk Laki, H.D., 920 Harket Street, Deliton, Haryland 21029	
te 31. Date filed (Month, Day, Year) 32. Registrar's Signature ar	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 5:00 PM DURHAM BUXTON AUGUST EARLEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **OUEEN ANNE** QUEEN ANNE COUNTY HOSPICE CENTER CENTREVILLE g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Days JULY 25, 1920 1 □ M 2 💢 F Vrs MARYLAND 215-18-8462 90 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland Director 1 X Yes 2 No CENTREVILLE **QUEEN ANNE** 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21617 104 TILGHMAN TERRACE . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. WHITE Completed 3 X Widowed 4 Divorced er than "natura; the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) OWN HOME HOMEMAKER th and Mental Hygien

27 is marked other the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be fil tment of Health and Mental tant: If item 27 is marked ပ HELEN LEWIS EARLE RANDOLPH DURHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 115 CHURCH HILL FARM LANE, SUDLERSVILLE, MD 21668 ROBERT BUXTON/ SON permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition MARYLAND VETERAN
CEMETERY AUGUST 23, XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HURLOCK, MARYLAND 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final holangio carcinoma Physician/ Months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 attending pl yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death signed by the a d be detached t g 🗌 Unknown g 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ iabetes 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No has disease coronary this certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be HOSPICE CENTER
6 X Other (Speciful examiner? Hospital Other: 4 Nursing Home 5 Residence 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred nours after death.

neral Director: After the funeral of the funeral filled in by the funeral filled in the fu Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined hours after To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Descripting Processing and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сопріете 29c. License number 29b. Signatur D 0055127 - MD aland MD 300 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 202 Coursevall Drive Scetald Centreville MD 21617 D. Malaro M.O.

DHMH 17 Rev 7/2009

Registrar

Margaret 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ ARBARA BOWERS 10:25A <sup>M</sup> Angust Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis 6310 River Crescent Drive 8. Date of Birth (Month, Day, Year 4/6/192 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Min. 1 M 2 T Louisiana 220-58-1243 89 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 0 an "natural", or items 23a o Medical Examiner must be Funeral USA 6310 River Crescent Drive 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black White etc þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Gift Shop Owner Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Brownell Huff Eva Grainer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Kimmel - Daughter 4002 Wayson Rd, Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 8/19/2010 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Þ Meselint Velober 47 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ FAILURE HEART CONGESTIVE disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: es, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Year Pregnant at time of death Yes ed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by þ HYPEILTENSION Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 277 Peninsula Farms Road Dr.William Dabbs 21012 Arnold. MD 31. Date filed (Month, Day, Year) AUG 1 8 2010 State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. NO. 0 | 0

			1 - State of Maryland / De State of Maryland / C	partment of Health and e <i>rtificate of Death</i>	-	2011	27622
	Physicia	ın/	Decedent's Name (First, Middle, Last)	on mouto or Douth	2. Date of Death	Day Year	3. Time of Death
	Media	al	Kennard Bryant  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	August	14 2010	10:25 A M
الصورات	Examir	er	SEASONS HOSPICE at NORTHWEST HOSPITA		ui	4c. County of Death  BALTIMORE	
-	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)			9. Birth	nplace (State or Foreign ntry) ageGrove MD
	nd how at	'n	Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or	Location			10d. Inside City Limits
	Maryla Ba-f s tified	<b>Funeral Director</b>		HEIGHTS			1 X Yes 2 ☐ No
	th the I 3a or 2 t be no	a Di	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	intry?
	ems 2	inne	2407 SENATOR AVENUE  11. Marital Status  12. Was Decedent Ever in U.S.  13. Marital Status	20747  3. Was Decedent of Hispanic Origin? (S		ISA 14. Race - Ameri	can Indian
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	δ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 ☐ No 1 Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puer  1 Yes 2X No Specify:	to Rican, etc.)	Black, White,	etc.
15-(	72 hou n "nati fledica	Completed	(Specify only highest grade completed) (Given	cedent's Usual Occupation re kind of work done during most of wo	rking 16	6b. Kind of Business In	ndustry
212	within giene. er tha		Elementary/Seconday (0-12) College (1-4 or 5+) GRAPH	DO NOT use retired) IIC ARTIST	DE	EPT OF DEFI	ENSE
and	e filed nta! Hy ed oth even!	To Be	17. Father's Name ( <i>First, Middle, Last)</i> JORDAN BRYANT		me (First, Middle, Mai	· · · · · · · · ·	50.35E-
aryl	ind Me ind Me s mark umatic			OLIVIA	MAE REDD		Code)
Z ×	nd 2 sl ealth a m 27 i		VIRGINIA BRYANT - WIFE 2407	SENATOR AVENUE			ARYLAND 2074
nore	age 1 a ent of H nt: If ite y or otl		¹XX Burial 2 ☐ Cremation 3 ☐ Removal from State   cemetery, ci	position (Name of ematory or other place)  VETERANS AUG		C. Location - City or T	·
Baltimore,	permit. P Departm Importar any injur		21. Signature of Funeral Service Licensee	22. Name and Address of Facility P	OPE FUNERA		
щ	<u> </u>		23a. Part 1. Enter the disease, o complications that caused the death. Do not e	5538 MARLBORO PIK			
	Pnysician/	6 10	snock, or heart failure. Lis only one cause on each line.  Immediate Cause (Final		or respiratory arrest,	1	Approximate Interval Between Onset and Death
ر	Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate  Athern) (ktofi (kin) in the conditions, but to for as a consequence of the conditions of the con	diovasular Diseuse			
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events  c				
_	cate be executed physician and sthe burial-transit	al E	resulting in death) Last Due to (or as a consequence of):				
3760	ficate to g physical as the to	<b>Nedical</b>	d			+	
39 X	th certi ttendin or use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy		23d. Date of deliv	
. Bo	the dea by the a sched for	Physician/M	1  Yes 2 No 4 Pregnant at time of death 5 9 Unknown	U Other (specify)		Month	Day Year
, P.O	s tha	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to t	
ords	require been s should	leted					bably 4 d Unknown
3ecc	The law cate has page 2 s	Completed			24a. Was an autopsy performed	prior to co death?	psy findings available impletion of cause of
tal	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Che			
<u>&gt;</u>	r this c	2	1 ☐ Yes 2 1 7 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 28a. Date of injury 28b. Time	ent 3 DOA Other: 4 Nursing Fof 28c. Injury at	lome 5 Residence	e 6 Other (Specify	ent nospil ?
ono	ending sath. or: Afte he fune	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work?  M 1 ☐ Yes 2 ☐ No	20g, Describe now in	пригу осситеа	
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	Route Number,
۵	lospita I hours uneral ed fillec	Medical	29a. Certifier (Check 2 Medical Examiner; On the basis of examination and/or inve	occured at the time, date and place, a	and due to the cause(s	s) and manner as state	ed.
	the Hithin 24 orthe Formplete		(Check 2 ☐ Medical Examiner: On the basis of examination and/or inveonly one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier.	death occurred at the time, date and place.  29c. License number	ace, and due to the cau	use(s) and manner as st	ated.
	F 3 F 8		► MS Ry & palmem · D	DUOS7463	- 29d.	Date signed (Month,	uay, rear)
e	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) S-203 - Raltic	nord Mr.	20205	
	Stat	e	30. Name and address of person who completed cause of death (Item 23a) (Type, N.S. Raj APA CH, M.D. 2835 Sm. TN M. 31. Date filled (Month, Day, Year) AUG 192010	1- 3-203 - PU 1111			
	Registra		AHG 1 9 2010 /2 June 1 1. Dave				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2<u>010</u> Physician/  $\underline{A}^{\mathsf{M}}$ AUGUST JEAN LORRAINE BROADIE 11:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🕱 F Hours (Month, Day, Year) Washington, Director 577-56-9653 Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ems 23a or r must be r Funeral 3800 Enfield Chase Court 20721 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status "natural", or iten edical Examiner 14 Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 Yes 2 X No 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify. 3 Widowed 4 X Divorced Completed Year or Dates Black al Hygiene. d other than "nature event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Computer Specialist Dept. of Justice should be filed w and Mental Hyg is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Oliver L. Humble t. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke Alice Jackson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle V. Wright / Daughter 2021 Brigadier Blvd. Odenton, Maryland 21113 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or o 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) HARMONY MEMORIAL PARK Aug 19 2010 LANDOVER MARYLAND Signature of Funeral Service Lic 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician ACUTE RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (o) as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit ISCHEMIA CARDIOMYOPATHY that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical SERVERE CORONARY ARTERY DISEASE Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 XNo 1 ☐ Yes ≥ L g ☐ Unknown detached q Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? CEREBROVASCULAR ACCIDENT LEFT 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? PERIPHERAL VASCULAR DISEASE 24a. Was an this certificate has performed? Yes 2X No 1 Yes 2 No DIABETES MELLITUS 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 XNo Other: ျှ 1 🔽 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 1 X Natural 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗆 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 221883 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St.

State Registrar Hema Yadla

AUG 1 9 2010

3001 Hospital Drive Cheverly, Maryland 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Albert Physician/ B. Bradford Jr. August 16 рМ 11:44 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex 1 AM 2 □ F . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 01-03-1970 Wash. DC 577–11–5427 Director 40 Usual Residence of Decedent Show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD PG Clinton 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8902 Cheltenham Ave. 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Plumbing-Steamfitter Apprentice Elementary/Seconday (0-12) 12 Bowers College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname)
Zemoria Metts 17. Father's Name (First, Middle, Last) ည Albert В. Bradford Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felecia Arthur-Bradford/Wife 8902 Cheltenham Ave. Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Harmony Memorial Park 8-21-2010 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) Ingrature of Juneral Service License 22. Name and Address of Facility Ronald Taylor II FH 108 West North Ave. Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Severe Anoxic Encephalopathy Sequentially list conditions. Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit Laryngeal Edema that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Left Submandibular Abscess Drainage Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has be funeral director, page 2 s autopsy performed? Yes 2 X No 2 XNo 1 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2**X**T No 1 🛚 Inpatient 2 🗆 Certificate: To 1 Yes ER/Outpatient 3 DOA 4 Nursing Hame 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred XNatural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 6 24 hours a Medical 29a. Certifier 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55856 08/17/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dr. Negash Ayele

31. Date filed (Month, Day, Year)

AUG 1 9 2010

32. Registrar's Signature

1500 Forest Glen Rd. Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 27625 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 22, 2010 Herman Bielfeld Brust, Jr. 7:05 AMM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 ₹ M 2 □ F Months Days Hours 82 1928 Mary Land 213-24-8157 June Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Middletown Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21769 4302 Valley View Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, was becedent Ever in 0.5.

Armed Forces?

1 □Xes 2 □ No

If Yes, Give 948-1954

Year or Dates 948-1954 Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Automotive Specialist

18. Mother's Name (First, Middle, Maiden Surname)
Myrtle Tritapoe

20c. Location - City or Town, State

Frederick, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig Code) 4302 Valley View Road, Middletown, MD 21769

Reeney and Bastord PA Funeral Home

Mount Olivet Cemetery Aug. 26, 2010

Date

Physician/ Medical **Examiner** 

permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical

for State Registrar

10a. State

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify) Fun- al Service Licens

Mrs. Jeannette Brust, wife

1X Burial 2 Cremation 3 Removal from State

Herman Bielfeld Brust, Sr.

Director

Funeral

ģ

Completed

Be

0

Physician/

Medical

Examiner

**Funeral** 

**Director** 

"natural", or items 23a or 28a-f shov edical Examiner must be notified at

72 hours after death

Baltimore, Maryland 21215-0036

been signed by the attending physician and should be detached for use as the burial-tran page 2 s certificate

Physician/Medical þ Completed within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be ၉ Certificate: Medical within 2 To the F

Hospital or Attending Physician; The law requires that the death certificate be

Division of Vital Records,

P.O. Box 68760

M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Minutes Cardiac Arrest disease or condition resulting in death) Due to (or as a consequence of) Minutes Exsanguination Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Minutes Disruption Vascular Graft right leg Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Months Peripheral Artery Disease, Infection IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1  $\square$  Yes 2  $\square$  No 3  $\overline{\mbox{N}}$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 💢 Xilo Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2**XX**No Other: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred XXNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 24773 August 22, 2010

915 Toll House Avenue, Frederick, Maryland

20b. Place of Disposition (Name of

State

Registrar

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Fox, MD,

SEP 0 2

31. Date filed (Month, Day, Year)

		For State	State o	of Marylar	nd / Depa	artment of F	lealth and	Mental Hy	giene 0	10	276	26
		Registrar  1. Decedent's Name (First, Middle)			Cer	tificate of L	)eath	_	Reg. No.			
Physici		Diane Monroe	, ,					2. Date of De Month	eath Day 20	) 1 O	3. Time of D	
Medi Exami		4a. Facility Name (if not institution		nber)		4b. City. Town, or	Location of Death			ty of Death	12:202	A W
		Casey House-Mo	ntgomery	Hospice		Derwood				tgome	ry	
Funeral		5. Social Security Number	6. Sex 1  M 2  XF	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. Birthp	lace (State or F	Foreign
Director		217-70-4060 Usual Residence of Decedent	I LI WI Z LAN	53	Yrs.	Months Days	Tiodis Will.	04/29/	1957	New	York	
and Show	5	10a. State 10b. County	,	10c. Cit	ty, Town or Loc	cation				1-	0d. Inside City	Limits
Maryla 18a-f	lect	Maryland Mont	gomery		Gaithe	rsburg					1  Yes 2	X No
a or 2		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?	
th with ms 23 must	Funeral Director	18401 Guildber				20879			Unite	d Stat	tes	
laryland 21215-UU36 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	11. Marital Status 1 Never Married 2 M Married 1 Never M Married 2 M M Married 1 Never M M M M M M M M M M M M M M M M M M M							ce - America ack, White, e y: Whit	etc.			
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Hygir Hygir other ent, t	Be	17. Father's Name (First, Middle,	Last)		] 56	cretary	18. Mother's Nan	ne (First, Middle,				
//and	은	Peter Monroe						y Anne				
Maryland 2 should be filed th and Mental Hy 27 is marked oft traumatic even	98	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street a	and Number or Rui	ral Route Numbe	r, City or Town,	- State, Zip C	ode)	
e, R and 2 Health em 27 ther tr		Blaine H. Cobl	entz (Spor			Guildbe	rry Driv	e, #101	Gaithe	rsburg	g, MD.	20879
DOF ge 1 a nt of H a If ite or ot		20a. Method of Disposition  1  Burial 2  Cremation		State C	emetery, crem	sition (Name of atory or other plac		st 18	20c. Location	•		
baltimor  bermit. Page 1  Department of  mportant: If it  any injury or o		4 ☐ Donation 5 ☐ Other (		Met		an Crema			Alexand		Virgin	ia
baltumore, Marylar permit. Page 1 and 2 should be f Department of Health and Menta Important. If item 27 is marked any injury or other traumatic en		I digratified Fulleral Services		orla	/	East De					MD. 20	877
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death c death c e atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █️XNo	1 ∐ Live I	Birth 2  Feta	ıl death 3 🗌	Ectopic pregnancy Other (specify)	/			ate of deliver onth	ry Day Yea	ir
the de cy the ached	hys	9 Unknown	9 🗆 Unkn	iown								
s that	by F	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the ur	derlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to the	e cause of deat	th?
aw requires as been sig 2 should b	ted					<u>.</u>	<del></del>	1 🗆 '	Yes 2 No	3 Proba	ably 4 🛣 Uni	known
law re has be	Completed							24a. Was autop	sy	prior to com	sy findings ava	ilable se of
i: The la		OF IN						1 Yes		death?	2 □ No	
siciar certifi	9 Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:			Othe	ce of Death (Chec					
g Phy er this eral d	e: To	27. Manner of Death	28a. Date of	Inpatient 2  of injury	28b. Time of	28c. Injury	4 □ Nursing Ho		lence 6 XOth ow injury occurr		Hospid	<u>ce</u>
andin sath. rr. Aft	licat	1 X Natural 5 ☐ Pendir 2 ☐ AccidentInvesti	gation	h, Day, Year)	injury	M 1 🗆	/es 2 □ No		, ,			
or Atter de lirecto	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place	of Injury - At ho	me, farm, stree	et, factory, office		28f. Location (S City or Tow	treet and Numb	er or Rural F	Route Number,	
pital o		00 0 W 4 X 0 W						K				- 1
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within E4 hours after death.  Completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical	(Check 2 $\bigsqcup$ Medical E	Physician: To the be xaminer: On the basi Nurse Practioner: 1	is of examination	and/or investi	gation, in my opinior	n, death occurred a	t the time, date a	nd place, and du	e to the caus	se(s) and manne	er stated.
To th withir To th comp		29b. Signature and title of certifier			owiedge, de	29c. License			29d. Date signe			
10		1 - 1level	etche	u, r	かり	DE	374	8	August	18, 2	010	
-		30. Name and address of person		,	, , , , ,	,						
Stat	6	J. Kouatchou M 31. Date filed-(Month, Day, Year)	.D. 6001 M	luncaste	er Mill	Road Ro	ckville,	Mary1ar	nd 20850	1		
Registra		AUG 2 0 20	10 Sene	egistrar's Signati	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Leonidas Ceballos 1544 2010 Augus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montaomeru Silver Spring Holy Cross Hospital 9. Birthplace (State or Foreign Country DOMLNICAN Republic . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 6. Sex **Funeral** 1 🗆 M 2 🕱 F (Month, Day, Year) May 04, 1932 219-47-4136 78 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Tyes 2 X No Burtonsville Montgomeru Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral Dominican Rebublic 14114 Aldora Circle 20866 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. by 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 K Yes 2 □ No Specify: 3 Widowed 4 Divorced Other White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Childcare/Housekeeping Domestic Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lorenza Ceballos Gregorio Toribio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 14114 Aldora Circle, Burtonsville, Maryland 20866 Mayra A. Medina - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 08/20/2010 Silver Spring, Maryland Gate of Heaven Cem. 4 Donation 5 D Other (Specify) 22. Name and Address of Facility Hines-Rinuldi Funeral Home, Inc. of Purieral Pervice Licen Le Whele 1800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Metabolic Acidosis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of attending physician and for use as the burial-transit Septic Shock that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Gram Negative Sepsis The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🗓 No Year Month Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has l lirector, page 2 s autopsy 1 Yes 2 X No 2 No or Attending Physician: Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes 2 🗓 No 1 X Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) this s after death.

I Director: After this
of in by the funeral d 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?

1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, To the Hospital or Att within 24 hours after d To the Funeral Direct completed filled in by t determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number ren August 17, 2010 D0065069

Registrar
DHMH 17 Rev 7/2009

State

and

Silver Spring.

Maryland 20910

1500 Forest Glen Road,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sirak Lemma, MD, 31. Date filed (Month, Day, Year)

10-06415 Susan Kim Coblentz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 27628

	1- For State Registrar	Certificate of	Death	Reg.	No. 2010	21020
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) SUS.	AN KIM COBLENT		August 25, 2	Day Year 2010	3. Time of Death 0505 hrs
	4a. Facility Name (if not institution, give street and nu Frederick Memorial Hospital	imber)	b. City, Town, or Location of I Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 6. Sex 1 1 M 2 KF	7. Age (In yrs. last birthday) 5 1. Yrs	If Under 1 Year If Under 2 Months Days Hours	8. Date of Birth Min. Jan. 6,	MM/DD/YYYY) 9. Birth Foreign 1.959 Cou	nplace (State or n ntry) Maryland
nd bow any cs.	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederick	10c. City, Town or Locati	on			10d. Inside City Limits 1 Yes 2 No
with the Maryland ms 23a or 28a-f show any be notified at once. eral Director	10e. Street and Number 7449 Franklinville Road		10f. Zip Code 21788	10g	U.S.A.	try?
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once leted by Funeral Director	1 3 Middwed 4 Hivorced III tes, Give tes	orces? If Y	s Decedent of Hispanic Origin es, specify Cuban, Mexican, P Yes 2 No specify:	uerto Rican, etc.)		ite
21215-0036 uld be filed within 72 hours after death Mental Hygiene. marked other than "natural", or ite c event, the Medical Examiner must To Be Completed by Fune	15. Decedent's Education (Specify only highest granning Elementary/Secondary (0-12)  College (1)  1.2	1-4 or 5+) during m	t's Usual Occupation (Give kinds of working life. DO NOT us memaker		6b. Kind of Business/Ir  Own Hot	·
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica			18.Mother's	Name (First, Middle, Ma a Carol Bro	iden Surname)	
MD 21; nd 2 should but and Men m 27 is mar aumatic eve		band 7449	Address (Street end Number Franklinville	Road, Thur	mont, MD 2	1788
re, slar free If ite	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal fi 4 Donation 5 Other Specify:	om State crematory or oth Blue Ridge	Cemetery 8		Thurmont,	
Baltimo permit. Page Department o Important: injury or oth	21 Signature of Funeral Service Licensee	ROB	ame and Address of Facility ERT E. DAILEY EAST MAIN ST	TUIDMONT	MD 21788	
Physician /Medical Examiner	Infinediate Cause (Final disease a.	done and fental aconsequence of):		diac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
in the second	Sequentially list conditions, if any, leading to immediate Due to (or as a cause. Enter Underlying Cause	a consequence of):				
tecuted and transit		a consequence of):				
760, cate be execu physician an he burial - tr	☐ AMENDED ☐ AMENDED 23a	,27,28a-f,per	ME g908 10/8/1	LO TT		
OX 687 eath certific attending procuse as tr		outcome of pregnancy  oirth 2 Fe  nant at time of death 5 Ot	tal death 3 Ectopic p		23d. Date of delivery Month D	ay Year
, P.O. B res that the d signed by the be detached d by Phy	5	o death but not resulting in the u	inderlying cause given in Part		acco use contribute to t	
Division of Vital Records, tal or Attending Physician: The law requires ris after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be prification: To Be Completed				24a. Was an autopsy perform	prior to co ed? death?	opsy findings available ompletion of cause of S
ital Recipion: The scertificate rector, page	25. Was case referred to medical examiner?	Inpatient 2 ✔ ER/Outpatient	26.Place of Death (C		esidence 6 Other	
n of Vilding Physical After this stuneral direction.	27 Manner of Death 28a Date	of Injury 28b. Time of I	njury 28c. Injury at Work?	1	winjury occurred took medi	vation
Division opital or Attending ours after death. eral Director: Aft filled in by the fund.	2 X Accident Investigation 3 Suicide 6 Could not be determined (Specify,	/25/10 Fd 4:00 ce of Injury - At home, farm, stree house		28f. Location (Str Rd or Tawn Sta	eet 1744 ymber or Ru Mont MD	el Route Number Eity
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier	of examination and/or investiga	red at the time, date and place tion, in my opinion, death occu	e, and due to the cause( irred at the time, date ar	s) and manner as state nd place, and due to the	d. e cause(s)
or Too	29b. Signature and title of certifier	stated.	29c. License number O.C.M.E.		29d. Date signed (Mon August 25, 2010	th, Day, Year)
	30. Name and address of person who completed cau. Pamela E. Southall, MD Assistant		1 Penn Street, Baltimo	ore, MD 21201		
Stat Registra	ATH. 'R H 2011   20	egistrar's Signature	Red			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month August 2010 3:21 Рм Physician/ Dorothy Louise Collins Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 9 Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country) Missouri Days (Month, Day, Months Hours 1 □ M 2 🛣 F 380-46-9044 64 Director 10. December Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🌠 Yes 2 □ No Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral United States 21 702 2118 Bristol Drive death v 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black White etc. permit. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". Any injury or other trainments. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Computer Programmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) မ Catherine Helen Francik Walter Benjamin Leehman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6307 Towncrest Court, Frederick, Maryland 21703 Charlene Mercer / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 28. 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland Smithsburg Crematory 2010 21. Signature of Funeral Service Licen Keeney and Bastord PA Funeral Home, 106 E. Maryland 21701 Church Street, Frederick, 23a. Park 1. Enter the disease, of shock, or heart failure. Listor Approximate Interval Between omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death 212010 Immediate Cause (Final Physician/ 0 ひ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner 3 ba Hospital or Attanding Physician: The law equires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death teen signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 🖵 Yes Completed pege 2 should . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) To the Funeral Director: After this certific completed filled in by the funeral director, Be examiner? Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 유 . Manner of Death 1 A Natural 2 Accident 28b. Time of 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 5 Pending Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 2010 MDD35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Myung Hee

Myung 31. Date filed (Month, Day Year)

Nam.

M.D

30

400

West

32. Registrar's Signature

Seventh Street, Frederick, Maryland 21701

				State of Maryla				-	_		
			For State Registrar		Cer	tificate of L			. No. 2010	27630	
G	Physici /Medic		Decedent's Name (First, Middle, La     Abby Coon				F	Date of Death Month HUQUST	Day Year 2010	3. Time of Death 3:67 A M	
	Examir		4a. Facility Name (If not institution, giv			***	Location of Death	J.	4c. County of Deat	h	
			The Johns Hopkins H  5. Social Security Number 6. 8		. last birthday)	Baltimore  If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth	9. Birt	hplace (State or Foreign untry)	
	Funeral Director			□ M 2 <b>X</b> F	Yrs.	Months Days	Hours Min. 12 9 A	(Month, Day, Yeug. 14,		ryland .	
	Maryland -f show ed at	tor	10a. State 10b. County	Anne's	ity, Town or Lo Steven	Location 10d. Inside City 1 September 27					
	with the 3a or 28a be notifi	Funeral Director	10e. Street and Number  101 Storm Haven	Court		10f. Zip-Code 2166	 56	10g	. Citizen of What Co	untry?	
	ms 2;	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.		lispanic Origin? (Specifian, Mexican, Puerto Ric	y Yes or No-	14. Race - Ame		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 □ Yes 2 XNo	Specify:	an, etc.)	Specify: V	, etc. Vhite	
5-0	72 ho natura lical E	Completed	15. Decedent's E (Specify onfy highest gr	ducation ade completed)	(Give	dent's Usual Occup	during most of working	16	b. Kind of Business/	Industry	
121	within ane.	ldmo	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. I	N/A	1)		N/A		
<b>d</b> 2	filed v Hygie Sther i	Be Co	17. Father's Name (First, Middle, Last,			IV/A	18. Mother's Name (F	First, Middle, Ma	*1/ **		
/lan	uld be Aental rked tic ev	To B	Ryan Coon				Meghan D	aley			
Maryland		n E	19a. Informant's Name/Relationship (	• •	1		and Number or Rural F aven Court		•		
	1 and 2 Health em 27	18	Bill Daley / Gra				Date	200	c. Location - City or		
Baltimore,	Baltimore,									, MD	
Balt	permit. Pag Department Important: I any injury o	5 5	21. Signature of Funeral Service Licer	see	Ba	arranco & 95 Ritchi	Sons, P.A. E Hwy,	Severr Severr	na Park Fu na Park, M	neral Home ID 21146	
			23a. Part 1. Enter the disease, or comshock, or heart-failure. List only	plications that caused the dea	th. Do not ent	er the mode of dyir	ng, such as cardiac or r	espiratory arrest	t,	Approximate Interval Between	
-41	Physician		immediate Cause (Final disease or condition resulting in death)	a Congenita	s hear	tdiseas				Onset and Death	
	/Medical Examiner		Testing in deathy	Due to ( r as a conse	quence of):						
	- 4-12	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b Due to (or as a conse	quence of):						
	ecuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	quanco of):						
.09	be exe	ical E	resulting in deathy East	Due to (or as a conse	quence oi).						
687	ificate g phys as the	Medi									
D. Box	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mohths? 1 ☐ Yes 2 ☐ Who 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	livery Day Year	
, P.O.	res that thigned by	by Pł	Part II. Other significant conditions	contributing to death but not re	esulting in the u	underlying cause gi	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
rds	v requires t been signe should be							1 🗌 Yes	2 No 3 □ Pr	obably 4 Unknown	
Records,	The law re ate has bee page 2 sh	Completed						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of	
of Vital	yslcian: The scentificate director, pa	Be (	25. Was case referred to medical examiner?	Hospital:		t a DOA Oth	26. Place of Death (C				
	Physl this c rral dir	은 :	1 ☐ Yes 2 ☑ No  27. Mannor of Death	28a. Date of Injury	ER/Outpatien 28b. Time o	f 28c. Injur	y at 280	5 L Residence d. Describe how		oify)	
sion	ath. r: After thi	ation	1 √Natural 5 ☐ Pending investigatio		Injury	M 1 _	k? Yes 2 □ No				
Division	pital or Attending Physician: ours after death. eral Director: After this certifica filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined			eet, factory, office	28f	. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,	
	To the Hospital within 24 hours a To the Funeral Completely filled	edical		nysician: To the best of my kn miner: On the basis of examin and manner stated.							
	Vithi Vomp	Š	29b. Signature and title of certifier	lah. mi	)	29c. License		29d	Date signed (Monti		
			- Juli	ge .	02-1/7		13577	1	TUgust	15, 2010	
			30. Name and address of person who	M. Nige	ein 23a) (Type,	enny	600 No	orth Wolfe	St, Baltimo	ore, MD, 21287	
	Sta	te	31. Date filed (Mohit Day YQ)201	22. Registrar's Sign	ature						

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Antoinette Crowley  $P^{M}$ 2010 Medical Aua 6:10 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crofton Care and Rehabilitation Crofton Funeral Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 J Months Days Hours Min. (Month, Day, Year 1916 Pennsylvania Director 118-05-9457 93 Nov. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10h County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits Crofton MD Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2427 Lizbec Court 21114 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien Homemaker Own Home permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Angelo DiBlase Carmela Tiora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2427 Lizbec Ct., Crofton, MD 21114 Jane M. Johnson / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 08/16/2010 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine death certificate be executed use as the burial-tran and that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? 1 | Yes 2 | No 9 | Unknown Pregnant at time of death signed by the a The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical upleted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? s after death. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one EOO 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 20 9 16 C

State Registrar

DHMH 17 Rev 7/2009

Rakesh Arora, 14300 Gallant Fox Ln., Suite 222, Bowie, MD 20715

Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Mont/AUG eg) 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [ ] [ ] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30.7 M Carter Osmond Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-RMC Cumberland Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Funeral 1 □ M 2 🔀 F Days Hours Sep 5, 1947 OH 62 **Director** 215-52-9284 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County Funeral Director 1 □XYes 2 □ No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 15612 Harvest Drive S.W. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) ည Ollie Clark Osmond James Robert Osmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>James Carter Jr.</u> husband 15612 Harvest Dr. SW Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/27/2010 Scarpelli Funeral Home\_P.A MDCresaptown 21. Signature of Funeral Service License 22. Nam Scarpelli Furferal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Overwhelming da disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Multiorgan aau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a con quence of): Cause (Disease or iinjury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier D0059987 Mistopher nous 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Seton Drive Cumberland MD 21502 Christopher Vagnoni 32. Registrar's Signat SEP 0 2 2010 State

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Registrar

			_ FOI	epartment of Health and	Mental Hygie	ene				
			riegional	Certificate of Death		g. No. 2010 27633				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month August	25 2010 3. Time of Death 5:15 A. M				
J,	Medic Examin		Vincent Charles  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
- /	LAditiii		Kline Hospice House	Mt. Airy		Frederick				
	Funeral Director	7	5. Social Security Number 6. Sex 1 $\boxed{\hspace{-0.2cm}\cancel{N}}$ M 2 $\square$ F 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You 04/28/19	9. Birthplace (State or Foreign Country) St. Lucia West Indies				
ii)	d ow t		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits				
	arylan a-f sh fied a	Funeral Director	,	derick		1 ▼ Yes 2 □ No				
	the M or 28 e not	اقًا	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?				
	s 23a nust b	era	5723 Crestridge Ct.	21703		United States				
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fur	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates.	<ul> <li>13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ∑ No Specify:</li> </ul>	oecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: black				
Maryland 21215-0036	thin 72 hour ene. • than "natu he Medical	Completed by	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	Decedent's Usual Occupation Give kind of work done during most of wor ife. DO NOT use retired)	king	6b. Kind of Business Industry  chool system				
d 2	lled wi I Hygid o <b>ther</b> /ent, t	Be	17. Father's Name (First, Middle, Last)	ducation officer  18. Mother's Nar	me (First, Middle, Ma					
ylar	ld be f Menta arked atic ev	၉	Reginald Glasgow	Geraldi	ne Charle	S				
Mar	2 shou h and 7 is m traum		1	Mailing Address (Street and Number or Ru						
<u>ē</u>	F Healt F Healt Item 2		20a. Method of Disposition 20b. Place of	23 Crestridge Ct., Disposition (Name of		Dc. Location - City or Town, State				
m <sub>O</sub>	Page 1 nent of int: If i		A Dulla 2 - Cleritation 5 - Heliovarillom State	, crematory or other place) hns Cemetery 08/2	8/2010	Frederick, MD				
Baltimore,	permit.  Departn Importa any inju		21. Signature of Funeral Service Licensee  Payelee W M01222	22. Name and Address of FacilityKee 106 E. Church St.,	ney & Bas	ford Funeral Home				
	Ph_sician/		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	the enter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death				
	Medical Examiner		resulting in death)  a.  Due to (or as a consequence of		014.7					
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	):						
7	uted nd ransit	Examiner	Cause (Disease or linjury that initiated events c							
	ate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of	):						
200	physic the p	edical	d							
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year				
P.O.	es that the des signed by the s be detached to		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?				
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Division of Vital Records,	The law recate has be page 2 sh	Completed by			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No				
ta	Physician: The r this certificate aral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Che		11				
of V	Phys rr this eral dir	<u>و:</u>	27. Manger of Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at	lome 5 Residence 28d. Describe how	ce 6 Other (Specify) 105 place				
ono	ending lath. Ir: After	icat	2 Accident Investigation	iury work?  M 1 🗌 Yes 2 🗆 No						
ivisi	I or Atte after de Directo	Certificate:								
П	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, do only one) 3 Certifying Nurse Practioner: To the best of my knowle	investigation, in my opinion, death occurred	at the time, date and	place, and due to the cause(s) and manner stated.				
	To the within To the comp	2	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)				
			Ferry Holl MD	1068104	,	8/26/2010				
	5		30. Name and address of person who completed cause of death (Item 23a) (TEric Rush MD 516 Trail A	ype, Print) Frederick	- mis	21702				
	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar SEP 0 2 2010									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 126-18-1413 1 🗆 M 2 📈 84 Months Davs Hours Min. March 21, Year 1926 Country York Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Prince George's Hyattsville 1 Yes 2 No 10f. Zip Code 10e. Street and Number 8610 21st Place 10g. Citizen of What Country? 20783 Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Ves Give SpecifyWhite 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other tl Homemaker Own Home permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other amy injury or other traumatic event, tt once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Winklarek Magdalena Mossner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7204 John Pickett Road, Woodbine, MD 21797 19a. Informant's Name/Relationship (Type, Print) Maureen Freeman/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Aug. 2010 MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature (Funeral Service Livensee ! Name and Address of Facility Francis J. Collins Funeral Home Inc. Mu 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ OU CH disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Due to (or as a consequence of): resulting in death) Last burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 the ası IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death ed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi

within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ only one 20 erson who complet cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

AUG

2 0 2010

Registrar's Sign

			For State	State o	f Marylan		artment of H		Mental Hy	ygiene	Э		
			Registrar  1. Decedent's Name (First, Middle	(- ( )		Cei	rtificate of	Death		Reg. No	2010	2	7635
п	Physic			_	tman				2. Date of D Month Augus	Da	ž, 2 <sup>Ye</sup>	3. Tir	ne of Death 1:30pM
Winds	/Medi Examir		4a. Facility Name (If not institution				4h City Town o	r Location of Deat			. County of D		1.30pm
5	Lxaiiii	lei	6513 Winder	-			**	Bethesda		10.	Montg		
	Funeral	8	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of B	irth	1 9	Birthplace (S	tate or Foreign
	Director		047-12-4567	1 <b>3</b> M 2 □ F		35 Yrs.	Mortus Days	Hours Min.	May 12	<b>,</b> 19.	25 Co	Country) nnecti	cut
	land bw		Usual Residence of Decedent  10a. State 10b. County	-	10c. Cit	y, Town or Lo	cation					10d. Insi	de City Limits
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	r dear	<b>Funeral Director</b>	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	S. 13. \	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (S	Specify Yes or N	0-	14. Race - A Black, W		an,
36	s afte ", or if	by Fi	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced	ried 1 XYes If Yes, Gir	2 □ No ve	_   1	□Yes 2 🔀 No	Specify:	To rinduit, ottory		Specify:	,	
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	ed	15. Deceden		ates: WWI]		lent's Usual Occup	nation		16h Ki	ind of Busine	Whi	te
215	nin 72 e. en "ne	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1	Apr E I \	(Give life. L	kind of work done of NOT use retired	during most of wo.	rking	TOD. IX	ind of Busine	33/IIIdd3ti y	
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Mai	d 2 st th and 7 is n		19a. Informant's Name/Relations				g Address <i>(Street)</i> B Winderm						5.2
ē,	Heal Heal tem 2	11.3	Lilo Ertman, 1 20a. Method of Disposition	Spouse	20b. P		sition (Name of patory or other place		Date Date		ocation - City		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State		oln Crema						
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m	Departing Departing Important in any irrespondent		LUSA			10	40 Rockv	ille Pik	e, Rock	ville	, MD 2	20852	
			23a. Part1. En ei the disease, or shock, o/heart fail v . List	complications that conly one cause on e	aused the death	. Do not ente	er the mode of dyin	ng, such as cardia	c or respiratory a	arrest,		Approx	imate Between
	Physician		Immediate Come (Final disease or condition				yopathy					Onset 5	Between and Death Years
1	/Medical Examiner		resulting in death)		or as a consequ								
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38760,	ficate be executed physician and s the burial-transit	dical		d									
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O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	☐ 1 ☐ Live b	come of pregna irth 2  Fetal	death 3 🗆	Ectopic pregnancy	y		1	23d. Date of o	delivery Day	Year
Ö	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregr 9 ☐ Unkno	ant at time of do	eath 5□	Other (specify)				World	Day	real
<u>.</u>	that the property detact	/ Ph	Part II. Other significant condition	ns contributing to de	ath but not resu	Iting in the un	derlying cause give	en in Part I.	23e. Did	tobacco u	se contribute	to the cause	of death?
Division of Vital Records,	quires tha	od by	Renal Insuffi	iciency					1 🗆	Yes 2≸	_ No 3 _	Probably 4	I ☐ Unknown
ပ္တ	aw requir s been s s should	Completed							24a. Was	an	24b. Were	autopsy findi	ngs available
ř	sician: The law certificate has b lirector, page 2 sl	ШО						<del></del>	auto perfo 1 ∐ Yes	rmed?	l death	o completion ? es 2 □ No	ings available of cause of
Ta	ctor, p	Bec	25. Was case referred to medical examiner?					26. Place of Dea			1 1 1	es ZLINO	
<u></u>	<b>F</b> in	၉	1 ☐ Yes 2 🚰 No		npatient 2 🗆 I		3 □ DOA Othe	er: 4 🗆 Nursing H	lome 5 ☐ Res	idence 6	6 □Other (S	pecify)	
ב	ding F h. After i funera	ioi	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		of Injury h, Day, Year)	28b. Time of Injury	28c. Injury Work	?	28d. Describe	how injury	y occurred		
<u>s</u>	death ctor: y the	licat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be	of Injury - At hor	ne form stre		Yes 2□No	29f Location /	Campatan	al 81:	Down I Davida	Ali for
2	ai or after	Certification:	4 ☐ Homicide determi	nea buildir	ig, etc. (Specify	)	et, factory, office		28f. Location ( City or To	wn, State,	)	nurar noute	varnoer,
	To the Hospitai or Attendin within 24 hours after death.  To the Funeral Director: Af completely filled in by the fur		29a. Certifier 1 Certifyin	g Physician: To the	best of my know	vledge, death	occurred at the tin	ne, date and place	l e, and due to the	cause(s)	and manner	as stated.	
	the Ho lin 24 the Fu	Medical		Examiner: On the ba	er stated.	ion and/or inv	estigation, in my op	pinion, death occu	urred at the time,	date and	I place, and d	ue to the cau	se(s)
	Vith vith	Σ	29b. Signature and title of certifier	1.11/1	1		29c. License				e signed (Mo		ar)
	10+1		· Much	-cuv				50512	U	0	1161	10	
			30. Name and address of person v				*	· · · · · ·	20252				
	Stat	e_	Michael Emmer (31. Date filed (Month, Day, Year)	32/Re	racy B1	vd, Be	thesda,	Maryland	20852				
	Registra		AUG 202	2010 Cen	egistrar's Signat	par	Keel						
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Registrar DHMH 17 Rev 1/2001

		1	For State Registrar	State	e of Maryla		artment of H rtificate of L			giene Reg. No. 0	0 6	27636
			1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month		'ear	3. Time of Death
	Physicia /Medic		Fr	ancis	С.	Eva	ins		August	19, 2010		3:45 P M
	Examin		4a. Facility Name (If not institution	, give street and	d number)		4b. City, Town, or	Location of Death		4c. County of		
a)			Caroline Home f				Dentor			Carol		(Otata as Familia
	Funeral		5. Social Security Number	6. Sex 1	_	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April 23	n y, Year)	Country	ce (State or Foreign V) Lvania
Ŋ	Director		210-28-1849 Usual Residence of Decedent	- X 2	73	115.			April 23	, 1937	ешьу	Tvailla
	and		10a. State 10b. County		10c.	City, Town or Lo	ocation				100	d. Inside City Limits
	Maryl f sho	ğ	Maryland Card	oline		Presto	n					1 ☐ Yes 2 ☐ No
	the 28a	Director	10e. Street and Number	71110		110000	10f. Zip Code			10g. Citizen of Wh	at Country	y?
	3a or	<u>_</u>	21408 Dover Br	ridge Ro	oad		2165	5	Ü	Inited Sta	ates	of America
	within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28a-f show the Medical Evanthatr must be rediffed at	Funeral	11. Marital Status		Decedent Ever in de Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No	14. Race	Americar White, etc	
٥	after or ite		1 ☐ Never Married 2 ☐ Marr	ied 1 □Y	es 2/17/No G. Give		1 □ Yes 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specific.		
5-0036	ours iral",	d by	3 XWidowed 4 ☐ Divorced	Year	or Dates:		,					asian
,	72 h 'natu	Completed	15. Decedent (Specify only highest	i's Education of grade comple	ted)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	king	16b. Kind of Busi	ness/indu	istry
7	vithin	dm	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+)		Maintenan	*		Hos	pita]	1
N	of filed within 72 at Hygiene.  other than "nai		12 17. Father's Name (First, Middle,	l ast)					ne (First, Middle,	Maiden Surname)		
yland	9 E D S	Be c	Francis	Evans	3			Heler	n Shoem	naker		
	is 1 and 2 should be filed of Health and Mental Hyg Item 27 is marked other other traumatic event, I	2	19a. Informant's Name/Relations			19b. Mail	ng Address (Street			er, City or Town, S	tate, Zip (	Code)
Mar	and 2 sealth all n 27 is	h h	Kimberly D. Boy		Daughter	161	Rose Road	, Schells	sburg, F	ennsy1va	nia	15559
တ်	s 1 ar if Hez Item othe	1 7	20a. Method of Disposition		20	b. Place of Disp	osition (Name of matory or other place	ne)	Date	20c. Location - C	ity or Tow	n, State
Ê	e = 5	1 1	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		rom State		metery	8/24,	/2010	Belsano,	Peni	nsylvania
Baltimore,	permit. Page Department Important: I any injury o		21. Sign Ture o Funeral Service	-		2	2. Name and Addre	ss of Facility Mod	ore Fune	eral Home	, P. A	Α.
ñ	Per Der	9	> Kandol	2016/1	our		12 South					
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications t	hat caused the d	leath. Do not er	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician	2. 7	Immediate Cause (Final disease or condition	orny one cause	on cach line.	renal	ic (1	rrhosi	7.		10	Onset and Death
	/Medical		resulting in death)	aDu	e to (or as a con	sequence of):		111000				35 47.53
مد	Examiner		Sequentially list conditions	b								
	p iii	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Du	e to for as a con	sequence of):						
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	e to (or as a con	on and a set to						
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8/60	cate   physi the b	dical		d			· · · · · · · · · · · · · · · · · · ·					
×	eath certific attending p for use as	Me	IF FEMALE:	23c. If ve	s, outcome of pre	eanancy				23d. Date	of delive	rv
Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 🗆	Live birth 2 1 I	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	у		Mon		Day Year
o.	at the de by the a tached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknown							
J.	that ned b		Part II. Other significant condition	ons contributing	to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use contrit	oute to the	e cause of death?
g	w requires that s been signed t should be deta	d by	Chroni	c re	nal.	Railu	re		1 🗆	Yes 2 No 3	3□ Proba	ably 4 🗌 Unknown
Records,	w rec s bee	Completed	Coror	19201	anter	J 6	disease	e	24a. Was		ere autop	osy findings available appletion of cause of
	The law te has age 2 s	mo							auto perfo 1 ☐ Yes	ormed?   de	eath?	
Vital		Be C	25. Was case referred to medica					26. Place of Dea				
	ding Physician: The h. After this certificate h. funeral director, page		examiner? 1 ☐ Yes 2 💆 No	Hospital:	1  Inpatient	2 ER/Outpati	ent 3 DOA Oth	ner: 4  Nursing H	lome 5 🗷 Bes	idence 6 □Othe	r (Specify	·)
0	ng Ph terth neral	i.i.	27. Manner of Death  1★ Natural 5 ☐ Pendir		Date of Injury (Month, Day, Yea	28b. Time Injury	of 28c. Inju	ry at k?	28d. Describe	how injury occurre	d	
õ	Attendir death. ctor: Af y the fu	atic	2 ☐ Accident investi	gation			M 1□	Yes 2□No				
Division of	r Att ter de irecto	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	cined 206. I	Place of Injury - A building, etc. (Sa	At home, farm, s becify)	treet, factory, office		28f. Location ( City or To	(Street and Numbe wn, State)	r or Rural	Route Number,
	ital o urs af ral D				T 11 1 1 1 1 1 1			ine data and plac	a and due to the	a acusa (a) and mar	anor as si	tated
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier  (Check only 2 Medical one)	Examiner: On	the basis of exal I manner stated.	/ knowledge, dea mination and/or	ath occurred at the ti investigation, in my	opinion, death occi	e, and due to the urred at the time	, date and place, a	nd due to	the cause(s)
	the ithin 2	Mec	29b. Signature and title of certifie		1//		29c. Licens	se number		29d. Date signed	(Month, I	Day, Year)
	F > F 8		) =	76	W.	MD	0	20475	534	8/2	0/11	Ò
J	1		30. Name and address of person	who completer	cause of death	(Item 23a) (Type	e, Print)		F	- 1		
			Wafik Zaki, M					, Marylan	d 2162	9		
	Sta	ite	31. Date filed (Month, Day, Year)	)	2. Registrar's S	Signature	- Ye					
	Regist	rar	AUG 84	2010	and the same	D. A.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ ENYINNAYA-OGBUEHI MERCY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL SILVER SPRING If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days oCT · 23 1 □ M 2 🗗 F Min. NIGERIA **1**925 212-43-2187 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at **Funeral Director** ty☐ Yes 2 ☐ No MD PRINCE GEORGE'S BELTSVILLE 23a or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3706 GREEN ASH COURT 20705 NIGERIA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6TH HOMEMAKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ IKPE ORIUMA LYDIA IKPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NNENNA NICHEGBN/DGT. 3706 GREEN ASH COURT BELTSVILLE, MARYLAND 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 9/7/10 ABIA, NIGERIA FAMILY PLOT 4 Donation 5 Other (Specify) J. B.JENKINS FUNERAL HOME 21. Signature of Funeral Service 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the discase, complications that cause 1 ms shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last by Physician/Medical Box 68760 s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗓 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 100 ဍ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manns of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide М Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year) 2010 9

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANNA LACHTCHININA

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra AMEND#23a IIperMF, 8/23/10, BW, Mcco Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Physician/ 3:050m Finkelstein Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Hebrew Home of Greater Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Ukraine Months Hours (Month, Day UQ . 22 **Director** 100 579-48-4813 Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hant: If it leem 27 is marked of other than "natural", or items 23a or 28a-f sho iury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6121 Montrose Road Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 XWidowed 4 Divorced Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Veterans Elementary/Seconday (0-12) College (1-4 or 5+) Administration Attornev Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Zelda Millstein Shlomo Finkelstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901 12001 01d Columbia Pike #511, Silver Spring, MD 19a. Informant's Name/Relationship (Type, Print) Dorcia Begun, Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Lebanon Cemetery | 08/19/2010 Adelphi, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St. . NW. Washington, 20012 23a. Part 1. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Prostate Cance disease or condition Years Medical resulting in death) Due to (or as a consequence of): Examiner month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the bunal-trar Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎇 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 2+

Registrar

Jefferson St. Ruckville, Md 20875

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT BERNARD FINNEYFROCK AUGUST 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days June 13, 1 X M 2 🗆 Hours Year 968 213-06-8834 Director 42 MaryTand Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d, Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4734 Mt. Zion Road 21703 U.S.A. death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Black, White, etc. "natural", or Completed by Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔽 No Specify. Specify: White 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Research Associate Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert M. Finneyfrock Marthena R. Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bradley Finneyfrock / Brother 558 Hooker Drive, Gettysburg, PA 17325 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Olivet Cemetery Mt. 8/19/2010 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Signature of Fureral Service Licen ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. Job 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that aused the deshock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician, Stage Disease disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death as been signed by the 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No has page 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Hospital: Other: မြ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 08/15/ D67657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Anish

31. Date filed (Month, Day,

Desai

NYT

32. Registrar's Signature

51

400 W

Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ DOUGLAS FARRINGTON 2010 ·19P Medical August 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Upper Chesapeake Medical Cntr. Harford Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 10/25/1965 New Jersey Director 184-62-1735 or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Delta PA York 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 17314 USA 262 Flintville Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates. Black White etc. ò 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. 12 <u>Fire Inspector</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Betty D. Hanna Thomas J. Farrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey Farrington/Wife Flintville Road, Delta, PA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 8/27/2010 Fallston, MD <u> Highview Mem.Gdn</u> 21. Signature of Furtheral Ser 22. Name and Address of Facility Kobert Harkins Funeral Home, Inc.,Delta, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir and Due to (or as a consequence of): physician s the burial Physician/Medical as IF FFMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 s performed Ves 2 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 chesapeako Drive Bel Air, MD21014 mo

Registrar

SEP 0 2 2010

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 | 1 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 24 2010 Henry Webster August 0500 Fearnow, Sr Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olney Montgomery Montgomery General Hospital 8. Date of Birth
NOV • 24, 1913 9. Birthplace (State or Foreign Social Security Number Sex 1. M 2 □ F 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** Hours West Virginia 578-10-8429 96 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important if item 27 is marked other than "nature" any injury or other traumatic events. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Rockville 1 ☐ Yes 2X No MD Montgomery 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral United States 14400 Butternut Court 20853 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?...
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates SpeciWhite Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) Public Transportation Bus Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ည Spielman Elizabeth Tyler Fearnow, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodbridge. VA Henry W. Fearnow, Jr 2605 Duxbury Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Cemetery Aug. 29,201♥ Berkeley Springs,WV Signature of Funeral Set ice Lig 22. Name and Address of Facility <sup>22. Name and Address of Facility</sup>
95 Union St.
Helsley-Johnson Funeral Home, Berkeley Springs, WV Moo522 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) neymonia **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 tonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 🗌 Yes ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director; /
completed filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olney, MD 20832 Atu Motumedi MD. 17904 Georgia Ave. Suite #304. 31. Date filed (Month, Day,

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month  $\overset{\mathsf{Day}}{1}4$ Physician/ DIANE A. GROM AUG 2010 4:17 P M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 🗌 M 2 🔀 F 4 7 1 4 7 1 9 5 8 California 550-33-3023 Director 52 Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygiene. Rant: If item 22, is marked other than "natural", or items 23a or 28a-f shoull up or other traumatic event, it he Madical Examiner must be notified at jury or other traumatic event, it he Madical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Alexandria Fairfax VA 1 🗆 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 22310 6804 Signature Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 XNo Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Contradts Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Maiden Surname)
Beverly Hilligoss ပ Richard Hudson 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6804 Signature Circle Alexandria, Va. 22310 Rudolph John Grom Jr/ permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 D Removal from State 8/17/2010 Beltsville, Md. Chesapeake Crem. 4 Donagon 5 Other (Specify) 9 Funeral Service Licenses HIMTO ADJEST THALDI FUNERAL SERVICE, P.A. 21. Signatura 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) CARCINOMATOUS MENINGITIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the as IF FEMALE: USe 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No ō Month Year 4 Pregnant Pregnant at time of death 5 Other (specify) signed by the at the detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy After this certificate has Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury **X**Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af

Completed filled in by the fu Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D60582 m completed cause of death (Item 23a) (Type, Print) 30. Marne and address of person who NATIONAL NAVAL MEDICAL BETHESDA MD 20-89-5600 J. KARAKUNNEI JOYSON

State

Registrar

31. Date filed (Month, Day, Year,

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32. Registrar's Signature

State Registrar greenhett, or D 2000

115 Centes way

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2 0 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month homas E. (r1665 4:00PM AUGU ST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKV 1110 0+ Greater Washi not per Montgomery Hebrew Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 1, 1920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Connecticut 1 🛛 M 2 🗆 F Months Days Hours Min. Director 85-14-954 90 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 🗌 Yes 2 🔀 No MD Silver Spring Montgomery 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1503 Ingram Terrace items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Year or Dates. 1942–45 Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marquerite Cannon Folward Gibbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 Ingram Terrace, Silver Spring, MD 20906 Catherine V. Gibbs/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cate of Heaven Cemetery 20c. Location - City or Town, State Injury or 1 X Burial 2 Cremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Myplardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner FIbrillation roxysmai Atrial Sequentially list conditions, Physician/Medical Examine Due to (or as a consequence or) it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial-Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy jo in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death led by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has k lirector, page 2 s autopsy performed 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitying Physician in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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ROCKVILL , MO

17/2010

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Timber (RNP

2. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Upon

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Alyson Timlin

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Grossnickle V. 9:10 P M Helen August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Williamsport Retirement Village Williamsport Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 19, 1 🗆 M 2 😾 F Year) 1922 Director 217-18-7133 88 Pennsylvania Usual Residence of Decedent or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director X Yes 2 □ No Williamsport Marvland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Funeral 21795 U.S.A. 154 N. Artizan Street death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Years Self-Employed Cosmetologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Levy Wolford Annie Lee Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 263 St. James Avenue, Woodbridge, New Jersey 07095 Judith Galvach - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 8/23/2010 Frederick, Maryland 4 Donation 5 Other (Specify) Stauffer Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility
Bast-Stauffer Funeral Home, P.A.
7606 Old National Pike, Boonsboro, Md. 21713 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between immediate Cause (Final Onset and Death Physician/ 6 Dais disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death signed by the a 2 🗌 No g Unknown 9 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown CANCOT, Concertive 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital funeral director. Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 4 Sursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury 24 hours after death Funeral Director: A 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie

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State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahid Mahmood 580 C Nov

AUG 2 4 201

S80 C Northern

Hacerstown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9 <u>2010</u> Physician/ Month 5:50a M William Jacob GEARHART August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerford Place Washington Hagerstown 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min Month, Day, Ye Maryland **Director** 88 214-16-1108 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 335 N. Mulberry Street 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates. 1951-59 White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 0 Truck Driver Food Storage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret S. Benner - Daughter 11018 Rosewood Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brownsville Cemetery 8/23/10 Brownsville, Maryland of Funeral Service Licer 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 20t Examiner 0 Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine 20 TRuctive Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the a Id be detached f 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen Renal Insuffier 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has i autopsy perform Yes 2 certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒️No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

3444

within 2

(Check

only one

29b. Signature and title of crifier

AUG 2 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

66,930

VANIA HAGERSTOWN MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16, 2010 Year Physician/ August Robert Garver 9:35 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mt. Airy Kline Hospice House Frederick If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 78 Yrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days XXM 2 D F (Month, Day, Year) une 2, 1932 Minnesota Director 347-24-5338 June Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 USA 2393 Bear Den Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
YEX Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: white If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Department of Army Research Physicist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Burdette Garver Daveda Hansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701 2393 Bear Den Road, Frederick, Maryland Shirley Garver - wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Neelsville Presbyterian 8-18-2010 Germantown, Maryland 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) emetery
22. Name and Address of Facility ature of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 orec disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and ed by the attending physician and detached for use as the burial-transit Exam Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown 9 Unknown s been signed by a should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has I autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ဥ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1) Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖊 😅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

29b. Signature and title of

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

>1

32. Registrar's Signature

Box 68760

Division of Vital Records,

29c. License number

arka

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner HYATTSVILLE trunce GEORG WUY5ing racilit If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Funeral Min. (Month, Day, Country) Director 10d. Inside City Limits 10a. State 10c. City. Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Completed by Funeral Director be notified 1 Yes 2 □ No MD Huattsville 10e. Street and Number 10g, Citizen of What Country? ō 15th avenue 20782 USA 5925 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Year or Dates 27 is marked other than "natur r traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) FOOD SERVICES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Carpenter UNKNOWN 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Guy HAETEIDGE Hyattsville, 40 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If its any injury or of once. 1 Burial 2 Cremation 3 Removal from State Suitland, MD 18 Ava 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License SH UPSHURST NW WASH, DC 20011 BIANCHI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To Be Completed by Physician/Medical Examiner physician and the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be exect resulting in death) Last Records, P.O. Box 68760 attending pl for use as tl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year Month Day been signed by the should be detached 9 Unknown Part II. Other significant conditions dontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Other: 2 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier son who completed cause of death (Item 23a) (Type, Print) Pd#Z16. ROCKVILLE

Registrar
DHMH 17 Rev 7/2009

State

d (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EARL THOMAS GORDON SR. August 6:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Hours Country) Maryland 219-18-8744 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified MD. Harford 1 ☐ Yes 2 🏋 No White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Bradenbaugh Road 21161 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ō Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced White Year or Dates. It of Health and Mental Hygiene.

If item 27 is marked other than "nature or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Boilermaker Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Gordon Guy Anderson Elizabeth Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21161 Jeanette M. Gordon (Wif Bradenbaugh Rd White Hall Date 27, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any injury or ot 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation Hamostead, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Mayleter Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph. sician/ Metastatic Line months cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, , Dementia, coronary wrtery 1 Ves 2 □ No 3 □ Probably 4 □ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print) 1-62 N Charles 701 32. Registrar's Signature 2

29b. Signature and title of certifier

29c. License number

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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		For State Registrar		State of N	/larylan	_	artment of I rtificate of L		Mental Hy	giene Reg. No.20	10	27650
Physicia		1. Decedent's Nam Clara Ju							2. Date of De Month Augus	D	AO10	3. Time of Death
Medic Examin		4a. Facility Name (if	not institution,	, give street and number)			4b. City, Town, o	r Location of Death		4c. County of Death Montgomery		
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min (Annth Pay York)								th	9. Birth	hplace (State or Foreign intry) D.C.	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>ک</u>	11. Marital Status 1  Never Marr 3  Widowed	ried 2 🛣 Marr	12. Was Decedent Armed Forces 1 Yes 2	Ever in U.S ? No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🎦 No		Specify Yes or No- to Rican, etc.) 14. Race - Am Black, Whi Specify: Whi			, etc.
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d 2 should alth and N 27 is ma		19a. Informant's Na Wade F. Ho				19b. Mail 1902	ing Address (Street Longmead Ro	and Number or Rui oad, Silver	al Route Number Spring,	er, City or Town, S MD 20906	State, Zip	Code)
Page 1 and ent of Her nt: If item ry or othe	- 1			3 Removal from Stat	e   0	emetery, cre	osition (Name of matory or other place Cemetery	ce) Aug.	Date 2010	20c. Location Washing	-	
permit. F Departm Importa any inju once,		21. Signature of Fu				2	2. Name and Addre Francis J. ( 00 Universi	ss of Facility	eral Home	. Inc.		
		23a. Part 1. Enter t shock, or hea	the disease or rt failure. Lis o	complications that cause only one cause on each li	ed the deat						<u>B 200</u>	Approximate Interval Between
Physician/ Medical Examiner		Immediate Cause ( disease or condition resulting in death)	(Final on	Due to (or as	s a consequ		tonitis					Onset and Death
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executed ian indicated	Examiner	cause. Enter Unde Cause (Disease or that initiated event resulting in death)	iinjury s	c. Due to (or as	s a consequ	Atria Jence of):	1 fibri	llation				
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Physicia this cert al direct	To Be	examiner? 1 Yes 2					ent 3 DOA Oth	er: 4  Nursing H	ome 5 Resi	dence 6 Oth		fy)
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		29b. Signature and	title of certifier	M ginh			29c. Licenso	e number 154996		29d. Date signe August	d (Month,	, Day, Year) <b>2010</b>
4		30 Name and address	A A	who completed cause of	death (Item		ina Ph	ilia De	.,01	ncy, M	9 ,	20832
Stat Registra	_	31. Date filed (Mont	, Day, Year)	32. Regist	rar's Signat		w	U	,			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:10 PM reda August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Laurel Regional Hospital Laure George's rince If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 7 F West Virginia 234-20-6911 89 Feb. 1921 Director Usual Residence of Decedent 28a-f show an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Beltsville 1 🗆 Yes 2 🔀 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11408 Rosedale Lane 20705 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify. Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Manager C&P Telephone Co. traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maggi Ella Ranson James Albert Burdette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Burdette -nephew 2500 Bison Road Fort Collins, Colorado 80525 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State any injury or Calvary Mem. Park 8/23/2010 Morgantown, West Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA <u>4400 Powder Mill Road Beltsville. Maryland 20705</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ neumonia Medical Examiner Fibrillation Esquentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hemodialysis physician and the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Fever Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sepsis Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown should peen Disseminated Intravascular Coaquilopathy 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No perform **Division of Vital** director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural Hospital or Attending 5 Pending 24 hours after death. Funeral Director: A 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F Destitying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 10 29b, Signature and title of certifie 10 D0066284 nd address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Suresh A

aurel Regional Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 27652 State of Maryland / Department of Health and Mental Hygiene 2010Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 18, Year Physician/ <sup>Day</sup> 2010 Lean Rucker Hendricks 8:55 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 16517 Copperstrip Lane Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** Country) Virginia Months Min July 5, 1925 1 3 M 2 □ F 579-26-3424 85 Director Usual Residence of Decedent 28a-f show 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Direct 1 Yes 2 No Maryland Mon toomery Silver Spring 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 16517 Copperstrip Lane 20906 IISA 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 'natural", or þ 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 21 No Specify: 3 X Widowed 4 □ Divorced Completed White Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) CPA Financial Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Hendricks Lydia Mae Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Shannon/Daughter 16517 Copperstrip Lane, Silver Spring, MD 20906 injury or other 20a, Method of Disposition 20b. Place of Disposition (Name o 20c. Location - City or Town, State Date Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation State Other (Specify) entoniument cemetery, crematory or other place) August 21 2010 Cate of Heaven Cemetery Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. West, Silver Spring,MD 20901 21. Signature of Funeral Service Licensee any 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the burial-transit that initiated events Due to (or as a consequence of): requires that the death certificate be exel resulting in death) Last physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b page 2 performed? 25. Was case referred to medica æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) ဂ္ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

18111 Prince Philip Drive, Olney, MD 20832

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan, MD

AUG 20

31. Date filed (Month, Day, Year)

D35635

August 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08711/2010 ELEANOR MAE HELMS 2320 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 10/18/1929 218-24-6626 MD Director 80 Usual Residence of Decedent items 23a or 28a-f shover must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1X Yes 2 □ No MD Washington Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11339 Gift Road 21722 USA Baltimore, Maryland 21215-0036

Permit, Page 1 and 2 should be filed within 72 horring papartnent of Health and Mental Hyoise Important: If item 27 is marked any injury or other any inju 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 ☐ Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Owens Lucille Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Woods - daughter 11339 Gift Road, Clear Spring, MD 21722 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Jarusalem Ch Cem 8/21/10 4 Donation 5 Other (Specify) Poolesville, MD Snowden Funeral Home of Funeral Service Licensee 22. Name and Address of Facility 21. Signature 246 N. Washington St, Rockville, MD 20850 23a. Fart Finter the disesce, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only the cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ASPHYXIATION MINUTES Medical Due to (or as a consequence of) Examiner OF EMESIS MINUTES HSPIRATION Sequentially list conditions, Examine Due to or as a consequence of if any leading to immediate cause. Enter Underlying Cause (Disease or liniury by the attending physician and tached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year Month Pregnant at time of death 1 Yes 2 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CEREBROVASCULAR ACCIDENT 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION page 2 s autopsy performed? Yes 2 No ANEMIA 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated extriving Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one 29b. Signature and 29c. License number D62553 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE ROCKVILLE MARYLAND PATSY MCNEIL MD m. 31. Date filed (Month, Day, Year) 3. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

AUG 20

DHMH 17 Rev 1/2001

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 10 27655  Certificate of Death  State  Registrar  Registrar														
	1. Decedent's Name (First, Middle, Last)								Reg. No.  2. Date of Death 3. Time of Death					
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Funeral Director		5. Social Security Number 579–22–3336	1 M 2 X F	7. Age (In yrs. Ia 9			Days Hours	Min.	8. Date of Birth (Month, Day May 13,	Year)	9. Birti Cou Vi r	nplace (State or Foreign ntry) ginia		
wo	1.	Usual Residence of Decedent												
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Uld be a Men marke	-	Vintan E. Payne	V. CT. (7.1.0)		1				garet Pay					
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations Sandra Mazzıllo/I	, , , , , ,				Street and Number ority Lane					Code)		
Baltimore, Dermit. Page 1 and Department of Hea Important: If item any injury or other		20a. Method of Disposition  1 scheme 2 □ Cremation  4 □ Donation 5 □ Other		State C	Place of Disponentery, crem	natory or other	of er place) L <b>Cemetery</b>	Aug	)ate 21		ion - City or 1	Town, State		
Baltimo permit. Page Department o Important: If any injury or	Ш	21. Signatur of uneral Service		1			Address P1 Facilities		The second secon		and, MD			
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Medical Examiner		resulting in death)	_ a	(or as a consequ										
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certificate be executed ording physician and use as the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):									
of the bur	dical		d											
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he de	hysi	1 Yes 2 X No g Unknown	g 🗆 Unk		Jean o L	-	Jiry)							
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DIVISION OT VITAI HECONGS, tal or Attending Physician: The law requires rs after death.  al Director. After this certificate has been signed in by the funeral director, page 2 should be an income and income an		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined 28e. Place	of Injury - At ho ing, etc. (Specify		et, factory, o	office	2	28f. Location (St City or Town		ımber or Rura	al Route Number,		
DIVISION OF VITAI KECC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical	g Physician: To the b Examiner: On the bar g Nurse Practioner:	sis of examination	and/or invest	igation, in my	opinion, death or	ccurred at	the time, date ar	d place, and	due to the ca	ause(s) and manner stated.		
To the within To the complete	2	29b. Signature and title of certific		O DOGE OF HIS	,omouge, u	29c.L	icense number				gned (Month,			
5		Dinne	Kuch	Lude	RNS	R	1151	08		Au	igust 19	, 2010		
		30. Name and address of person Diane Ruckert, CI				•	e, MD 2085	0						
Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 0 2	010 Sens	Registrar's Signat	face	J.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 23 2010 **Physician** Hazelriaa 0200AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washin Healthcare of Hujerstown 9. Birthp 7. Age (In yrs. last birthday) If Under 1 Year lace (State or Foreign 8. Date of Birth (Month, Day, Yea 5. Social Security Number **Funeral** Washington, D.C 1□M 2√F 6, Yrs. Dec. **Director** 579-38-5230 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural; or items 23a or 28a-1 shov ury or other traumatic event, it is Medical Examination was beneathing as No Yes 2 No Directo Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U. S. A. 21740 14014 Marsh Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Prince Georges County Elementary/Secondary (0-12) College (1-4or 5+) Board of Education School Bus Driver 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Unascertainable) Walter Duncan Zollinhofer Modesta 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Farragut Drive, Keedysville, Maryland 21756 Steven H. Hazelrigg - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 8/24/2010 Frederick, Maryland Stauffer Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bast-Stauffer Funeral Home Donald 7606 01d National Pike, Boonsboro, Md. 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 heiner **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine signed by the attending physician and debetached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Obstructive Pulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has i autopsy performed? res 20 No certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 this Director: After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number R 118578 nevetuler completed cause of death (Item 23a) (Type, Print) 14014 March Pike Hajerstown MO 21742 3H-4 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

AUG 24 2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	/larylan		rtmen tificate					110	27657	
			Decedent's Name (First, Middle, Last	")						2. Date of De	ath		3. Time of Death	
	Physicia Medic		Charles Wal	ter Hayte	er					August	20 Day 20	10 <sup>Year</sup>	4:25 P. M	
	Examin		4a. Facility Name (if not institution, give	·			-		ocation of Death	1	4c. County of Death			
-			14 School Hous					onsbo			Washington			
	Funeral Director		5. Social Security Number 6. Se 229-34-0500	X M 2 □ F 7. A	ge (In yrs. Ia 80	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Pa July 10	th ly, Year) 1930	9. Birth Coun Virc	place (State or Foreign htry) yinia	
	id now	_	Usual Residence of Decedent  10a. State 10b. County		I 10c Cit	y, Town or Loc	ation						10d. Inside City Limits	
	arylar a-f sl fied	Director	Md. Washir	naton		Boons							1 □YYes 2 □ No	
	or 28 or 28		10e. Street and Number	-9 00	1	200118.	10f. Zip	Code			10a. Citizen of	of What Country?		
	with t	Funeral	14 School House	Circle					21713		J	U.S.	-	
õ	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	11. Marital Status 1 ☐ Never Married 2 ૐMarried	12. Was Decedent Armed Forces 1 Yes 21 If Yes, Give	t Ever in U.S ? ] No	If	Yes, spec	ify Cuban	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bl	ace - Americ ack, White,	etc.	
9500-612	urs a tural* al Ex	ted	3 Widowed 4 Divorced	Year or Dates.			☐ Yes				Specia	y: 	White	
င်	72 ho n "na ledic	Completed	15. Decedent's Ed (Specify only highest grad	de completed)				k done du	tion I <mark>ring m</mark> ost of wor	king	16b. Kind of	Business In	dustry	
717	/ithin iene. r tha	Ç	Elementary/Seconday (0-12)	College (1-4 or	5+)	ille. DC	nor ase	Dri	ver			Bus		
D	filed v tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)						18. Mother's Nar	ne (First, Middle,	Maiden Surnar	ne)		
Jar	d be f Menta arked	욘	Charles Minton	Hayter					1	Bessie M	iae Kest	ner		
Maryland	should be file h and Mental 7 is marked of traumatic eve		19a. Informant's Name/Relationship (Ty)			1	_	,	nd Number or Ru		. ,	. ,	·	
	and 2 lealth em 27 her tr		Gloria M. Hayter	(Wife)		1			e Circle					
saitimore,	ge 1 s nt of h : If ite		20a. Method of Disposition 1 Description 3 D	Removal from Stat	te C	lace of Disposemetery, crem	atory or o	ther place,	Aug	Date 24,	20c. Location	•		
	it. Partruck		4 Donation 5 Other (Specify	,	Smi	thsbur			J ; =	1.0	SIIII CI.	sburg	,Μα.	
д. Д	Deps Impo any i		21. Signature of Funeral Service License		MO141				of Facility Funeral	Home Sn	525 Bra ithsbur	dbury g,Md.	Ave. 21783	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or			h. Do not ente	r the mod	of dying,	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	Lun	1 Con	ca						Onset and Death Tyr.	
	Examiner		resulting in death)	Due to (or a	s a consequ	ience of):							,	
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or a	s a consequ	ience of):						-		
	ansit	amir	if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury											
	execu an and rial-tra	EX	that initiated events resulting in death) Last	Due to (or a	s a consequ	ience of):				<del></del>				
2	ate be executed physician and the burial-transit	edical Examiner		d							<del></del>			
200	rtifica ling pl e as tl		IF FEMALE:	20- 16										
DOX	ath ce attend for us	Physician/M	in the past 12 months?	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant	n 2 ∐ Feta	ıl death 3 🖳	Ectopic p					ate of deliv	ery Day Year	
Ď	/ the c	ysic	1  Yes 2 No 9 Unknown	9 Unknowr		Jean 3	Other (sp	ecity)					,	
у. Э.	that the	by PI	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the ur	nderlying o	ause give	n in Part I.	23e. Did t	obacco use cor	tribute to t	he cause of death?	
,	uires n n sigr	ed b								1 🗗	Yes 2 □ No	3 🗌 Pro	bably 4 ☐ Unknown	
<u> </u>	w req is bee 2 shou	plet								24a. Was		. Were auto	psy findings available impletion of cause of	
Vital Records,	The la	Completed								auto perfo 1 🗆 Yes	ormed?	death?		
0	sian: ertifica ctor, l	Be (	25. Was case referred to medical examiner?	F				_	ce of Death (Che					
5	hysic this ce al dire	မ	1 Li Yes 2 Z No			ER/Outpatient			4   Nursing F	ome 5 Resi			)	
0	ding F	ate	27. Manner of Death  1 Natural 5 Pending	28a. Date of in (Month, D	jury lay, Year)	28b. Time of injury	- 1	Bc. Injury a work?	at ′es 2⊡No	28d. Describe I	now injury occu	rred		
200	deatl ctor: y the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		niurv - At ho	me, farm, stre	M et. factory		es 2 LINO	28f Location (	Street and Num	her or Rura	Route Number,	
DIVISION OF	al or A		4 ☐ Homicide determined		etc. (Specify		,,			City or Tov		oor or mara	rioate rampol,	
-	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examin										ed. use(s) and manner stated.	
	the Lithin 24	Me	only one) 3 Certifying Nurs				eath occur	red at the	time, date and pla		e cause(s) and r	nanner as st	ated.	
	5 × 5 0		29b. Signature and title of certifier	2001	/	0- 0	290	License i	l I I I I	_	29d. Date sign	ea (Month,	uay, Year)	
			30. Name and address of person who co	Ville	dooth (tto-	220)/[:::::: 0::	rimt\	U	~1166	)	0	6.3	. 70	
5	4-4		A	Clorno	ik	i Zoa) (Type, Pr	s /	redi	ical Ca	engu	Baje	ったし	na MD	
	Stat Registra		AUG 2 4 20	10 Sz. regis	trar's Signat	1. So	MA							

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 08 2010 6:15 P M **Physician** 20 Catharine Hill Laura /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examine Caroline Denton Homestead Manor If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 02/23/1922 if Under 1 Year 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 ☐ YF 88 NJ 145-12-0931 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 □Yes X□No Goldsboro Director Caroline 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21636 25409 Golt Farm Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White Specify: \$ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Goeke Bergen Harvey Vandyke ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 25409 Golt Farm Lane, Goldsboro, MD Judy Erhardt Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dover, DE Capitol Crematory 8/23/2010 22. Name and Address of Facility
Moore Funeral Hone, P.A., 12 S. 2nd St., DEnton, MD 21629 21. Signature of Funeral Service Lice \* Koullet 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Advanced Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c, if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a d be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 2 100 After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 **1**0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To JUN WIS 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation e Hospha. ב n 24 hours after death. the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. the within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 MD 00053355 2010

State Registrar Molinda

31. Date filed (Month, Day, Year)

BU 32. Registrar's Signature AUG 8 4 2010

136 Lednum

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #25 Per ME G90/ 9/02/10 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 Month Year Physician/ Betty May Hann 06:05 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner ltimore 8. Date of Birth (Month, Day, Yea If Under 1 Year \_ If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) Sex ( **Funeral** Country)
Maryland Min. 218-26-3890 Director 1930 Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Upperco Baltimore 1 ☐ Yes 2X No Maryland 10f, Zip Code 21155 10e. Street and Number Og. Citizen of What Country? United States Completed by Funeral 15715 Hanover Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 X Married white 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-003 3 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lola L. White ည Arthur C. Cullison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 19a. Informant's Name/Relationship (Type, Print) Upperco, Maryland 21155 15715 Hanover Road Raymond F. Hann / husband Date 12 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aug. 2010 cemetery, crematory or other place Carroll Cremation 1 Burial 2 X Cremation 3 Removal from State Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home . Signature of Funeral Service License HAmpstead, Maryland 21074 M01072 934 South Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset an Death Immediate Cause (Final Physician/ remorn disease or condition Medical resulting in death) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine (or as a consequence of) NED BY MEDICAL attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Records, 1 🗆 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should to Completed 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? 2 1 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, ☐ Natural ☐ Accident 5 Pending 2 No 3 2010 Investigation act 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License numbe WJL 000 2 person who completed cause of death (Item 23a) (Type, Print 30. Name and address of 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Known

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANNA LOUISE CALLAHAN HUNTER 2010 2:25 P M AUGUST Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT EASTON TALBOT HOSPICE HOUSE If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. oct. I3, 1915 1 □ M 2 👿 F MARYLAND 94 Director 217-14-8229 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland Director SEAFORD 1 🗌 Yes 2 🗶 No DE SUSSEX 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 19973 USA 5388 NEALS SCHOOL ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. ı "natural", or item edical Examiner n 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 11 -0-Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARGARET HELEN BLADES WILLIAM O. CALLAHAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5388 NEALS SCHOOL ROAD, SEAFORD, DE 19973 19a. Informant's Name/Relationship (Type, Print) LYNNE BANNING/GRANDDAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State CHESTERFIELD CEMETERY AUGUST 21, CENTREVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. nset and Death Immediate Cause (Final lzheimeris Physician/ emen tra ear disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Ecquentially list our ditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed -tran and Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 ereh rovascular accident 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be HOSPICE HOUSE Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 2000 မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dil this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌

State

Registrar

LAKSHMI VAIDYANATHAN, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

2010

August

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryland	d / Depa <i>Cer</i>	artment of I <i>tificate of I</i>	Health and Death	Mental Hy	giene Reg. No. 2010	27661
Physicia	an/	1. Decedent's Name (First, Middle, Last)  Dori	C M	Haser	nei		2. Date of De	ath Year	3. Time of Death
Medî Exami		4a. Facility Name (if not institution, give stree	et and number)	Haser	4b. City, Town, o	r Location of Deat		4c. County of Dea	
Funeral	μ	Kline Hospice Hou  5. Social Security Number   6. Sex	SE 7. Age (In yrs. las	st birthday)	Mt. A	iry Tif Under 24 Hrs	8. Date of Birt	Frederic	thplace (State or Foreign
Director		214-14-5828 <sup>1 □ N</sup>	12¤F 88	Yrs.	Months Days	Hours Min	Feb.	19,1922 Co	Maryland
land show dat	tor	Usual Residence of Decedent  10a. State  10b. County		Town or Lo					10d. Inside City Limits
ie Mary r 28a-f notifie	Direc	Maryland Frederi	ck Wal	kers	ville			10g. Citizen of What Co	1X Yes 2 □ No
s 23a c	Funeral Director	3 Chapel Place			2179	3		United S	-
Nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	b	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Xho If Yes, Give Year or Dates.	1	Vas Decedent of H f Yes, specify Cuba □ Yes 2 XNo	an, Mexican, Puer		Black, Whit	
Z1Z15-0U36 within 72 hours after giene. fer than "natural", o	Completed	15. Decedent's Educa (Specify only highest grade o	completed)	(Give I	dent's Usual Occup kind of work done ( O NOT use retired)	during most of wo	rking	16b. Kind of Business	Industry
212 212 I within ygiene. her tha he, the N	Be Cor	12	College (1-4 or 5+)		Maker			Own Home	
Maryland 2 should be filed th and Mental Hy 27 is marked out traumatic even'	lo B	17. Father's Name (First, Middle, Last) Unknown					me (First, Middle, KNOWN	Maiden Surname)	
Mary should and N is ma		19a. Informant's Name/Relationship (Type,						r, City or Town, State, Zi	
or Health of Health fitem 27		20a. Method of Disposition		ace of Dispo	sition (Name of	- 1	Walker:	SVILLE, M. 20c. Location - City or	
<b>Baltimore,</b> permit. Page 1 and Department of Hea Important: If item any injury or other once.		1 XBurial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)		dlaw	natory or other place n Cemet	ery  31,	2010	Baltimor	
Depar Depar Impor any ir		21. Signature of Funeral Service Licensee	401612	K€	Name and Address eney and 6 East C	sseffsefford hurch St	PA Fune	eral Home erick, MD 21	1701
F <b>riysici</b> an/		23a. Part DEnter the disease, or complicate shock, or heart failure. List only one commediate Cause (Final disease or condition	tions that caused the death. ause on each line.						Approximate Interval Between +n_et and Death
Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					
sit sd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iiniury	Due to (or as a conseque	#100 cf);				1,1	
execution and an and rial-trar	Exa	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):					
/60 cate be physici s the bu	edical	d							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Months 9 ☐ Unknowh	If yes, outcome of pregnan    Live Birth 2 Fetal    Pregnant at time of de   Unknown	death 3	Ectopic pregnand Other (specify)	су		23d. Date of de Month	olivery Day Year
ds, P.O. quires that the en signed by a	ρ	Part II. Other significant conditions contrib	outing to death but not resu	lting in the u	nderlying cause gi	ven in Part I.		obacco use contribute to	o the cause of death?  Probably 4 Unknown
VITAI HECOTAS, ysician: The law requires is certificate has been siç director, page 2 should b	Completed	25. Was case referred to medical					1 🗆 Yes	osy prior to death?	utopsy findings available completion of cause of
VITA Nysiciar Nis certif directo	To Be	examiner?  1 □ Yes 2 No	oital:	R/Outpatier	Oth	ace of Death <i>(Che</i> er: 4  Nursing I	2. 1	dence 6 Other (Spec	HOSDICE
ION OT tending Ph leath. tor: After th the funeral	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	28b. Time of injury	M 1 🗆	y at	28d. Describe h	now injury occurred	
DIVISION tal or Attendir s after death. al Director: After the fu		4  Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number or Ru vn, State)	ıral Route Number,
the Hospiti nin 24 hours the Funera	Medical	(Check 2 Medical Examiner: only one) 3 Certifying Nurse Pr	n: To the best of my knowle On the basis of examination ractioner: To the best of my	and/or invest	tigation, in my opinion leath occurred at th	on, death occurred e time, date and pl	at the time, date a	and place, and due to the	cause(s) and manner stated.
viti or or		29b. Signature and fittle) of certifier	of mo		29c. Licens	e number	4	29d. Date signed (Mont	h, Day, Year)
8		30. Name and address of person who comp	eleted cause of death (Item 3	23a) (Type, P	Print)	enak.	m) 2	1702	
Sta Registr		31. Date-flied (Month, Day, Year) SEP 0 2 2010	32. Registrar's Signatu	bare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:30PM CAROLYN D. HANSON August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Med. Center Harford 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 0/24/1943 Country) 218-40-9519 Director 10/ Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits ıral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location death with the Maryland Director MD Harford 1 🗆 Yes 2 🔀 No Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2105 Swartz Road 21034 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Black, White, etc. þ Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2x No Specify: Specify: White 3 Divorced 4 Divorced Completed other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Care Provider Day Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be flied nt of Health and Mental H I: If item 27 is marked ot ပ္ Mike D. Bebber Mary Comer Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Homer W. Hanson/Husband 2105 Swartz Road, Darlington, MD 21034 permit. Page 1 and 2
Department of Healt
Important: If item 2
any injury or other: 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baptist View Cem. 8/28/2010 Forest HIll, MD 21. Signature of Tune Service 22. Name and Address of Facility Harkins Funeral Home, Inc., Kolsen Delta, PA complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. List ediate Cause (Fig. 1) Interval Between Onset and Death Immediate Cause (Final BTUE Physician/ MONTHS disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) I by the attending physician and etached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has b director, page 2 s autopsy perforr death? 2-N Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Certificate: To 1 Enpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred

or Attending Physician: The law requires that the death certificate be executed funeral director. 24 hours after death, Funeral Director: A filled in by Hospital

28a. Date of injury (Month, Day, Year) injury work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

29a, Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00028

ロサインエンは中の 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATWOODREADBE PHICA P WAVAT

State Registrar

Medical

SEP 0 2 2010 filed (Month, Day, Year) 32. Registrar's Signature

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 25, Day 201 Öear Physician/ Janey Mable Clyburn Henry  $J \mathbf{u}^{\text{Month}} \mathbf{y}$ 3:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgcmery Silver Spring Althea Dale Age (In yrs. last birthday) 95 vre If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 03/1 1 □ M 2 🏋 F Months Davs Hours Director Carolina Unknown Usual Residence of Decedent Fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State MD 10d. Inside City Limits Director Montgomery Silver Spring 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27901 USA 1000 Daleview Dr. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Bace - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: Black 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Self Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Clyburn Agnes 19a. Informant's Name/Relationship (Type, Print) . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
45 Millbrook Dr. APt.H Winston Salem, NC Karen Cuff/Grandaughter 2045 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 A Cremation 3 Removal from State Riverdale Crem. 08/02/2010 Riverdale, MD 4 🗌 Donation ☐ Other (Specify) une al Service l'icense and Address of Facility Dunn & Sons Funeral Home 21. Signature of 20019 5635 Eads St. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Acute Myocardial Infraction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Adult Onset Diabetes years Sequentially list conditions, if diry, leading to immediate cause. Enter Underlying Examine Due to for sels consequence of, Advance Degenerative Joint Diesease signed by the attending physician and de detached for use as the burial-transit years Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♠No Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by № No 3 Probably 4 Unknown director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 [XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

DHMH 17 Rev 7/2009

State Registrar

Smith Ho

31. Date filed (Month, Day, Year)

only one)

29b. Signature and title

Denve S. Sark

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7610 Carroll Ave #280 Takoma Park, MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D21900

29d. Date signed (Month, Day, Year)

8/4/2010

20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			-	State of Maryland	/ Department of H	ealth and Mer	ntal Hygier	ne	
		•	1 - State Registrar	, , , , , , , , , , , , , , , , , , , ,	Certificate of L		Reg. N	2010	27664
			Decedent's Name (First, Middle, Last)	41	_		Date of Death	ay Year	3. Time of Death
	Physici /Medic		Lynn A.	Heinbaugh			ugust	232010	1110PM
•	Examin		4a. Facility Name (If not institution, give st.	eet and number)	4b. City, Town, or	/	1	tc. County of Death	tona
			5. Social Security Number 6. Sex	7. Age (in yrs. la	st birthday) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	9. Birthola	ce (State or Foreign
	Funeral Director			/ 2□F 71	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, Yea 2C . 7 . 1	or) Countr 938 PA	ice (State or Foreign y)
			Usual Residence of Decedent	/					
	arylan show	<u>.</u>	10a. State 10b. County		Town or Location			10	d. Inside City Limits 1 ☑ Yes 2 ☐ No
	8a-1	Director	MD Washingt	on W	illamsport		100.4	Citizen of What Countr	v?
	a or 2		10e. Street and Number	on Dood	21795		, 59.	USA	,.
	d within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f show the Medical Examene must be motified at	Funeral	16730 Hampt	2. Was Decedent Ever in U.S.			Yes or No-	14. Race - America	
9	or Iter		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give	1 ☐ Yes 2 ☑ No	n, mexican, Puerro Hica Specify:	an, etc.)	Black, White, e	
Maryland 21215-0036	iral', d	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1.0		
15-(	"natu	Completed	15. Decedent's Educi (Specify only highest grade	completed)	16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired.	furing most of working	i	Kind of Business/Indu	•
12	withir ene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Civil enginee			LICCUITO I	OWCI GO
<b>d</b> 2	Hyg Hyg Sthe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (F.	irst, Middle, Maid	en Sumame)	
ılan	d to be	ToB	John	Heinbaugh			Heinbaug		
lary	and and sm aum		19a. Informant's Name/Relationship (Typ		19b. Mailing Address (Street a				
	s 1 and 2 f Health item 27 other tra	1 8	Siri H. Heinbau		16730 Hampto			rt, MD 21 Location - City or Tov	795 vn. State
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		ice of Disposition (Name of metery, crematory or other place rview Cemetery			rcersburg,	
Itim		1	' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Leans			ss of Facility Lin:			
Ba	permit, Departr Imports any inji		The total			rk Ave., Me	0		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.					Approximate Interval Between
	Pnysician	s v	Immediate Cause (Final disease or condition	lancre	the Conce				Onset and Death
ŕ	/Medical		resulting in death)	Due to (or as a conseque					ésissan en
	Examiner		Sequentially list conditions, b.	D to (or	2222.26).				
	ed	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events c.	Due to (or as a conseque	ence ory:				
_•	axecut and al-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):				
760	ite be executed iysician and he burial-transit	cal	d						
99	leath certificat attending phy I for use as the		IC CEMALE.						-300
Вох	ath ce ttendii or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths?	<ul> <li>c. If yes, outcome of pregnant</li> <li>1 ☐ Live birth 2 ☐ Fetal</li> </ul>	death 3 Ectopic pregnancy			23d. Date of deliver Month	y Day Year
	the all	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ath 5 ☐ Other (specify)				
P.0	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the		Part II. Other significant conditions conf	ributing to death but not resul	ting in the underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
Records,	uires tha signed Ild be dei	d by					1 🗆 Yes	2 ☑No 3 ☐ Proba	ably 4 □Unknown
CO	w requir s been si should	Completed					24a. Was an	24b. Were autop	sy findings available
Re	The lav te has	E					autopsy performed 1 ☐ Yes 2 ☑	?death?	2 □ No
Vital		BeC	25. Was case referred to medical examiner?			26. Place of Death	Check onlone		
of V	Phyalcian: this certificanal director, I	10	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 E	The second second second	4   Nuising Home		6 □Other (Specify	)
D L		9	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wor 1 □	yat 280 k? Yes 2 □No	d. Describe how i	njury occurred	
isio	tent leatl tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injury - At hor	me, farm, street, factory, office	-	Location (Street	t and Number or Rural	Route Number,
Division	after a	Certification;	4 Homicide determined	building, etc. (Specify,	)		City or Town, S.	ta te)	
	To the Hospital or Attena within 24 hours after death To the Funeral Director: completely filled in y the	Salc	29a. Certifier 1 Certifying Phys	ician: To the best of my know	vledge, death occurred at the tir on and/or investigation, in my o	ne, date and place, and	d due to the cause	e(s) and manner as sta	ated. the cause(s)
	the Hin 24 the Fu	ledical	опе)	and manner stated.				Date signed (Month, I	
	To To	Σ	29b. Signature and title of certifier	Moral	29c. Licens	1667	l	2 - 2 3 4 / C	
		П							
			30. Name and address of person who co	a Cormecle	23a) (Type, Print) 110 Nedical ure S. forkel	Compas	place.	stren, M	1
	St	ate	31. Date filed (Month, DSEP) 0 2	20162. Registar's Signat	ure A bank				
	Regist	rar	9 to 1 U m	Christer	p. prouve				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 3. Time of Death Nellar Mae Hill Physician/ 2010 1958 Medical 4a. Facility Name (if not institution, give street and number)
St. Mary's Hospital 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Mary's Leonardtown Social Security Number 238-54-8141 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
NC Months Days Hours Min (Month, Day, Year) 7/26/1929 81 Director Usual Residence of Decedent 10a. State NC 28a-f show 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Wilson Wilson 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 4510 Hatcher Lane Funeral items 23a 27896 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married δ Yes 2 X No Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Black "natural", Specify: 3 Widowed 4 Divorced Completed Me fical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Supply Technician Private traumatic event, Be 17. Father's Name (First, Middle, Last)
Ernest Bullock 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Bertie Best 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettie H. Atcherson/ dtr MD 20659 35451 Army<u>Navy Dr. Mechanicsville</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/15/2010 Wilson, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus Funeral Service Licens Carrons F.H. 22. Name and Address of Facility 325 Nash St. Wilson, NC 27893 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on each line COLON CANCER Immediate Cause (Final ABOVE 20 YRS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ASCITIS 2 WEEKS Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) ending physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death 5 Other (specify) detached the 9 Unknown g 🗌 Unknown s been signed by t should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown LIVER LESIONS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 2 certificate 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗆 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mapper of Death nours after death.

neral Director: After the filled in by the funeral 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral Completed filled Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 29c. License number 5 C Galoh D54346 August 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chandra B. Sajja, M.D. 24305 Three Notch Rd

State

Registrar

31. Date filed (Month

AUG 3

Registrar's Signature

Hollywood, MD

20636

Sajja,

2010

		4	Plea Amended Item 6 p	ase Type or per I D 0 State o	<b>Print in</b> 18/13/10 of Maryla	Black II 0 Carro nd / Depa	n <b>delibl</b> o 11 Co artment	e Ink	t. <b>Ens</b> i J <b>il</b> lealth a	ure Al and M	I <b>I Copie</b> ental Hy	s Are	e Legib	le.	
			1 State Registrar	* 45		Cei	rtificate	of D	eath			Reg. No	201	0	27666
	Physicia Medic		•	Ann John							2. Date of De	t 9	<sup>ay</sup> , 201 <sup>Y</sup>		3. Time of Death 22:40 M
and a	Examin	er	4a. Facility Name (if not institution) Carroll Hospit	al Center			V	Vest	Location o	er			Carr	·o11	
	Funeral Director		5. Social Security Number 219-74-0851	6. Sex 1 XM 2 X F	7. Age (In yrs. 53	last birthday) Yrs.	Months Days Hours Min as Month Day Year						9. Birthplace (State or Foreign Country) MD		
	aryland a-f show fied at	Director	Usual Residence of Decedent  10a. State 10b. County  MD C	arroll	10c. C	Sykesville									0d. Inside City Limits 1   Yes 2 □ No
	ith the Ma 23a or 28 st be noti		10e. Street and Number 7636 N. School	h D			10f. Zip	Code	0 /.			10g. Ci	itizen of Wha	t Coun	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Department of Health and Mertall Hyglene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status  1 K Never Married 2 Marital Status  3 Widowed 4 Divorced	12. Was Dece Armed Fo 1  Yes	edent Ever in U rces? 2 <b>X</b> No e		Was Decede If Yes, specif	nt of His y Cubar	spanic Orig n, Mexican	gin? (Spec , Puerto R	ify Yes or No- lican, etc.)		14. Race - A Black, V Specify:		etc.
Maryland 21215-0036	thin 72 hou ene. than "natu he Medical	Completed	15. Deceder (Specify only highe Elementary/Seconday (0-12) 12	nt's Education est grade completed) College (1	-4 or 5+)	(Give	dent's Usual kind of work O NOT use i Servi	done di retired)	uring most	,	-		and of Busin		
land 2	be filed wi ental Hygid ked other ic event, t	o l	17. Father's Name (First, Middle, L Unknown			1 1004	Bervi		18. Mothe		(First, Middle, Johns	Maiden		, _ 1.	
Mary	d 2 should alth and M 27 is mar er traumat		19a. Informant's Name/Relationsh Miss Aften Joh		ghter)		-				Route Numbe				
Baltimore,	Page 1 an ment of He ant: If iten ury or othe		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 4 ☐ Donation 5 ☐ Other (S		Ctata	Place of Dispo cemetery, cren 1 Coun	natory or oth	ner place	ion 8		ate 2010		ocation - City esvill		
Balt	permit. Departi Import any inj once.		21. Signature of Funeral Service L	icensee Haugt	M007	164 P	2. Name and O Box	Address	s of Facility	HAIG esvi	HT FUN 11e, M	ERAL D 21	HOME 784	& C	CHAPEL
10	Tiysician/	6 3	23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	complications that conly one cause on ea	aused the dea	ath. Do not ente									Approximate Interval Between Onset and Death
	Medical Examiner	L	resulting in death)	Due to (	or as a consec			ทห	en	on	1 '5				-
_	executed an and ial-transit	Examiner	Sequentially list conditions, if any local sequentially cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (	or as a consol	wence uty									
			resulting in death) Last	d	or as a consec	quence of):									
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Lunera Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		Birth 2  Fet	tal death 3 🗌	Ectopic produced Other (spe		1			23d. Date of delivery Month Day Year			
ls, P.O.	uires that to n signed build be deta	ed by P	Part II. Other significant condition				inderlying ca	use give	en in Part I		23e. Did to				e cause of death?
Division of Vital Records,	he law req te has bee age 2 shou	Completed	mulhi	rile s	u- Sclere	Lize					24a. Was autor perfo	psy ormed?	prior deat	to con	sy findings available inpletion of cause of
ta	cian: I ertifica ector, p	Be	25. Was case referred to medical examiner?	[Uses Note				1	ce of Deat	h (Check o		22/11/		100	
Į <	Physic this or	욘	1 Yes 2 No  27. Manner of Death	Hospital:	<del>, '</del>	ER/Outpatier			4 ∐ Nu		ne 5 🗆 Resid			pecify)	
o uo	ending leath.	Certificate:	1 Natural 5 ☐ Pendin 2 ☐ Accident ☐ Investig	g (Mont gation	h, Day, Year)	injury	M 286	c. Injury work?		- 1	3d. Describe h	now injur	y occurred		
Divisi	ital or Att urs after d ral Directo lled in by t		3 Suicide 6 Could I	ined 28e. Place buildir	ng, etc. (Specif					-	City or Tow	vn, State,	)		Route Number,
	ne Hosp n 24 ho ne Fune pleted fi	Medical	(Check 2 L Medical E	Physician: To the be xaminer: On the bas Nurse Practioner:	is of examination	on and/or invest nv knowledae. o	tigation, in my death occurre	y opinior ed at the	n, death oc time. date	curred at the and place.	he time, date a and due to th	and place e cause(s	e, and due to t s) and manne	he cau r as st <i>a</i>	se(s) and manner stated.
	をできる		29b. Signature and title of certifler				29c. [	License	number	5		29d. Da	te signed (M	onth, D	ay, Year)
	7		30. Name and address of person v	who completed caus	0	m 23a) (Type, P	Print)		Roc	-d	we	1(-n	nin/1	kr	4 12 1157
	Stat Registra		31. Date filed (Month, Day, Year)	3 2010 32. Re	strar's Signa	ature A. A	farke	,							

**Funeral** Director

ng physician and as the burial-transit The law requires that the death certificate be executed attending physician Box 68760 nse ned by the a edetached f P.O. signed I Records, Division of Vital

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Barbara 4:20A M Jacobs August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Seasons Hospice @ Northwest Randallstown 8. Date of Birth (Month, Day March 7 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 TTT 6. Sex 7. Age (In yrs. last birthday) Min. 1 □ M 2 □**X**F Months 232-38-5106 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Insportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c, City, Town or Location Randallstown 10d. Inside City Limits Director Baltimore 1 🗆 Yes 2 🖁 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21133 4224 Powells Run Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) education secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bethel McGinnis Chester Parrish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1080 Carriage Hill Ct., Annapolis, MD 21401 Susan Jacobs (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Lake View Mem. Park 8/16/2010 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licen≴ee PO Box 195 Sykesville, MD 21784 Hull 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End-Stage Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant : 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 menths?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other specify) Hospital Other: 욛 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nskajapamem.D WIL DO057465 8/12/10 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MO. 21209. N.S. Rajapakse, M.D. 2835 Smon AV-5-203, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar	Ce	ertificate of D	eath		Reg. No.		
	Physicia	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Pay Yea								
	Medic		Dennis Joyne				0.8		UIU	0345AM
	Examin	er	4a. Facility Name (if not institution, give street and num Anne Arundel Medical Cen			napolis		4c. County Anne	of Death Aru	
	Funeral Director		246-88-5712 <sup>1</sup> ★ M 2 □ F	7. Age (In yrs. last birthday) 56 Yrs.	) If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da) Oct. 9	y, Year)	Cour	place (State or Foreign ntry) h Carolina
	nd <b>how</b> at	'n	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	Location					10d. Inside City Limits
	laryla 3a-f s ified	ect	MD Prince George's	Bow	rie					1 🗶 Yes 2 🗆 No
	or 28	ä	10e. Street and Number		10f. Zip Code		Ī	10g. Citizen of	What Cou	ntry?
	with s 23a ust b	Funeral Director	15748 Pointer Ridge Dr.		20716			United	Stat	es
	death item		Armed For	dent Ever in U.S. 13	B. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spec	cify Yes or No-		ce - Americ	can Indian,
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ★ Married 1 ☐ Yes 3 ☐ Widowed 4 ☐ Divorced If Yes, Giv. Year or Da	2 <b>X</b> No	1 ☐ Yes 2X☐ No		, , , , ,		· Whi	
2-C	2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)		edent's Usual Occupa re kind of work done du		ıq .	16b. Kind of B	usiness In	dustry
121	thin 7 ane. than ne Me	Completed	Elementary/Seconday (0-12) College (1-	4 or 5+) life.	DO NOT use retired)			Const		4.00
S N	be filed wit lental Hygie rked other ic event, th	a)	17. Father's Name (First, Middle, Last)	l Gerre	ral Superi	18. Mother's Name	(First, Middle,	Const		1011
au	be fil lental rked ic ev	မ	Paul Joyner			Helen Gl			,	
ary	should and Me is mar raumati		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street ar	nd Number or Rural	Route Numbe	r, City or Town, S	State, Zip	Code)
	1 and 2 s of Health of item 27 i		Michelle A. Joyner / Wif	e 157	48 Pointer	Ridge Dr	., Bow	ie, MD 2	20716	
Baltimore,	tof H If itel or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from		position (Name of rematory or other place	) D	ate	20c. Location	- City or To	own, State
텵	t. Page rtment c rtant: If rjury or		4 ☐ Donation 5 ☐ Other (Specify)	Metro Cr				Baltimo		MD
Ra	permit. Page 1 a Department of the Important: If ite any injury or of any injury or of once.		21. Signature of Funeral Service Licensee		22. Name and Address					
			23a. Part 1. Enter the disease, or complications that of	aused the death. Do not er	6512 NW Cr.			•	<u>/15  </u>	Approximate
	Pnysician/		shock, or heart failure. List only one cause on ea Immediate Cause (Final	ch line.						Interval Between Onset and Death
	Medical		disease or condition resulting in death)	or as a consequence of):	ell carrie	en.			-	
	Examiner		Sequentially list conditions	or as a consequence of):	1 conce	-				1 month.
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequence of):	• ,					
	cutec	Examin	that initiated events	or as a consequence of):	silvec				$\rightarrow$	
	cate be executed physician and the burial-transit	SalE	resulting in death) Last	or as a consequence oi).						
09/8	certificate be executed nding physician and use as the burial-transi	Medical	d						$\pm$	
χ X	h certifi tending r use æ			come of pregnancy Birth 2  Fetal death 3	☐ Ectopic pregnancy	1			ate of deliv	
, Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician		nant at time of death 5	Other (specify)			Mo	onth	Day Year
л Э	s that i	by P	Part II. Other significant conditions contributing to de	eath but not resulting in the	e underlying cause give	en in Part I.				he cause of death?
dS,	quires en siç ould k	ted					1 🗆 '	Yes 2 4 No	3 🗌 Pro	bably 4 🗌 Unknown
Division of Vital Records,	e law re has be ge 2 sh	Completed					24a. Was autop	rmed?	prior to co death?	psy findings available ompletion of cause of
<u> </u>	in: Th tificate or, pa		25. Was case referred to medical		26. Pla	ce of Death (Check		2 <b>O</b> No	1 Yes	2 L No
VII.	ysicis is cert direct	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital:	inpatient 2  ER/Outpati	Other			dence 6 🗆 Oth	er (Specifi	v)
5	ng Ph fter th meral	ite:	27. Manner of Death 1  Natural 5  Pending  (Mont	of injury 28b. Time injury injury		at 2		ow injury occurr		
<u>o</u>	tendii leath. tor: Ai the fu	ifice	2 Accident Investigation		M 1 □ Y	res 2 No				
NIS	Il or At after of Direct d in by	Certificate:	4 D Hamisida determined 28e. Place	of Injury - At home, farm, s ig, etc. <i>(Specify)</i>	street, factory, office	2	28f. Location (S City or Tow	Street and Numb rn, State)	er or Rura	l Route Number,
_	Hospita Hours Funeral sted fille	Medical	29a. Certifier 1 Certifying Physician: To the box (Check 2 Medical Examiner: On the bas	s of examination and/or inve	estigation, in my opinion	n, death occurred at t	the time, date a	nd place, and du	e to the ca	use(s) and manner stated.
	o the	Ě	only one) 3 Certifying Nurse Practioner: 29b. Signature and title of certifier	o the best of my knowledge	e, death occurred at the 29c. License			e cause(s) and m 29d. Date signe		
	ÉD		Indent Dalin	.0.	Hao	70481		08/17	7/1	010
	6		30. Name and address of person who completed caus	e of death (Item 23a) (Type	Ause	, , , , , , ,		-0/1.	10	
			Keith Govlet 600	Ridgely	Aunuc	Ang	polis,	MP		
	Stat Registra	e ir	31. Date filed (Mont/AUG 1 8 2010 32.	egistrar's Signature	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 16 Day 2010 Year Physician/ 1358 Nathanie1 Jacobs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital 8. Date of Birth Dec 16, 1934 Birthplace (State or Foreign Country)
 DC If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **Ϫ**M 2 □ F Months Days Hours DC 75 Director 578-44-2079 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🔀 Yes 2 🗌 No Suitland Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò "natural", or items 23a o Funeral 20746 United States 3940 Bexley Place # 605 . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married X Yes Specify: Black Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Self-Employed 12th Cab Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Jacobs Theresa Edward Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3203 Good Hope Ave. # 512 Temple Hills, Md. 20748 Darryl A. Jacobs Sr./ Son Baltimore, 20b. Place of Disposition (Name of cemetery crematory or other place)
Mary Land Veterans 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State □ Donation 5 □ Other (Specify) 2010 Cheltenham, Maryland Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. tun of Funeral Service Lice se Sid 20019 Benning Road NE Washington, DC ot enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or complications that caused the Approximate 23a. Part 1 shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Dav Year Pregnant at time of death 5 Other (specify) 2 🗌 No the a 9 Unknown detached 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Jas , page 2 performed 1 Yes 2 No certificate Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: ျင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Griffing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year

cem

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

7600

32. Regist ar's Sig

29c, License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Trudy F. Kolodny 2010 17 3:44  $A^M$ August Medical 4b. City, Town, or Location of Death Derwood 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Casey House- Montgomery Hospice Montgomery Social Security Numbe Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 180-34-5228 1 □ M 2 🖼 F Months Days Hours Min Jan. 31 Year 1942 Peffffs lvania Director 68 Yrs. Usual Residence of Decedent or 28a-f shown notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Gaithersburg Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral 20878 United States 785 Kimberly Court West 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noural", or iten I Examiner n 14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 X Married timore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. "natural" Completed 3 Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Doctor's Office Office Manager 12 should be filed wit lith and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Vivian Cohen Benjamin Shtatman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a If item 27 is Jeffrey B. Kolodny (Son) 252 Quincy Avenue, Long Beach, CA 90803 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it cemetery, crematory or other place)
King David
Memorial Gardens 1 XBurial 2 Cremation 3 Removal from State August 19, 4 Donation 5 Q Other (Specify) Falls Church, Virginia 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funera 10 East Deer Park Drive, Gaithersburg, MD 20877 M00689 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short or heart failure. List only one cause on each line.

Immediate Cause (Final Non Small Cell Lung Cancer Interval Between Onset and Death Physician/ Non Small Cell Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Lause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 1 ☐ Yes 2 🔀 No 1 Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🐴 No Hospital Other: ၉ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ieral Director: After filled in by the funer 1 X Natural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

Hospital To the Hospital within 24 hours a To the Funeral 1D

> 31. Date filed (Month, Day, Year) State AUG 20 2010 Registrar

29a. Certifier

only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nicole Christenson, CRNP-F, 6001 Muncaster Mill Rd., Derwood, MD 20855 . Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) August 17, 2010

29c. License number

R120698

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Matthew Patrick Kane 2:48a M August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 **X** M 2  $\square$  F (Month, Day, Year) Washington. Director 63 Yrs. 578-60-8083 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3749 Castle Terrace 20904 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 2 X No 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Kathleen Ann Gallagher Matthew Joseph Kane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3247 Saint Augustine Court, Olney, Maryland 20832 Mary Katherine Cook - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Lincoln Crematory 08/24/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Perforated Abdominal Viscus disease or condition Medical resulting in death) Examiner Metastatic Colon Cancer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months? Pregnant at time of death 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 X No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No ျှ 1 Tes 1 🗓 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred the Funeral Director; After appleted filled in by the funer 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined To the Hospital within 24 hours a To the Funeral E Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52503 August 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Shailesh Sheth.

AUG 2 0 2010

31. Date filed (Month, Day, Year)

MD,

32. Registrar's Signature

1500 Forest Glen Road, Silver Spring, Maryland 20910

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Menth Avanell D. Keith 2010 1:15PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll 4726 Ruggles Rd. Taneytown Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Hours 9/4/193 280-32-8918 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Taneytown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4726 Ruggles 21787 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? 1 ☐ Yes 2 X No If Yes, Give If Yes, specity Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white 3 ☐ Widowed 4 🄀 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 House Work <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willard Archer Surber Ruby R. Poore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ken Keith / Son 720 W. Myrtle St., Littlestown,PA 17340 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mountain View Cemeter .6/201D Harney, MD 21. Signature of Funeral Service 22. Name and Address of Facility 17340 Little's F.H. 34 MAple Ave. Littlestown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate

Physician/ Medical Examiner

permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical

Physician/

Medical

10a. State

MD

Director

Funeral

Completed by

Be

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**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-tran signed by the a d be detached f within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s

Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition resulting in death)	Lung CA			Onset and Death
	resulting in death)	Due to (or as a consequence of):			
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
	Cause (Disease or illinury that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
dical	<b>U</b> d.	l			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 modils? 1  Yes 2  No 9  Unknown	3c. If yes, outcome of pregnancy 1			23d. Date of delivery Month Day Year
2	Part II. Other significant conditions cont	tributing to death but not resulting in the underlying	cause given in Part I.		use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  No 1  Yes 2 No
Ř	25. Was case referred to medical examiner?		26. Place of Death (Check	( only one)	
9	1 ☐ Yes 2 ☐ No	ospital: 1	OOA Other: 4 \( \sum \) Nursing Ho	me 5 Residence	6 Other (Specify)
Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)  M  28b. Time of injury  M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inji	ury occurred
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	ry, office	28f. Location (Street a City or Town, Star	nd Number or Rural Route Number, le)
edical	(Check 2 Medical Examine	cian: To the best of my knowledge, death occured a er: On the basis of examination and/or investigation, in	my opinion, death occurred at	the time, date and place	e, and due to the cause(s) and manner stated.

29d. Date signed (Month. Dav. Year)

Caster Street Wastyluster, MD 2157

DHMH 17 Rev 7/2009

State Registrar

WJL 12 29b. Signature a

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. Amend 21 per FH 6907 9/15/10 nk Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ D740AM 2010 Mae Kemp Anna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** aston Talbot Memorial Hospital Eastor Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Oci 27 1926 Hours Min. 1 □ M 2 🗓 F Pennsylvania 83 Director 218-20-5755 Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔽 No Maryland Caroline Goldsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral with U.S.A. 21636 15154 Jarrell permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. The protectant if item 27 is marked other than "natural", or items amy injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 09 inspector computer technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ William Foster Hickey Delsya Pearl Everett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15118 Jarrell Road; Goldsboro, Maryland 21636 Sharon Holden/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 29, 2010 Mt. Olive Cemetery Felton, Delaware 4 Donation 5 Other (Specify) 22. Name and Address of Facility PO Bx 160; Greensboro, R Fleegle and Helfenbein Funeral Home, PA . Signature of Funeral Service Licensee MD 21639 Stephen C. Fleegle per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediat cause. Enter Underlying Cause (Disease or linjury Examiner death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 9 🗌 Unknown Inknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autonsv perfor ☐ Yes 2☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After t 1 Natural injury 5 Pending 1 Yes 2 No Investigation Accident completed filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide determined Medical Actifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of perso no completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) gistrar's Signature State AUG 97

DHMH 17 Rev 7/2009

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Certificate		2010 27671
Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. No U U Z D 4  Death 3. Time of Death
Physician	Month	79 20/0 1954 M
/Medical MARIE J. KNOX  Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Total	wn, or Location of Death	4c. County of Death
6602 Landing Way Land		Prince George's
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1. Months D	avs Hours Min. (Month,	Day, Year) Country)
Director 579–58–7606 G4 Yrs. Usual Residence of Decedent	3/12/	1946 Washington, DC
0		10d. Inside City Limits
Maryland Prince George's Landover		1x∑Yes 2 No
Maryland Prince George's Landover  106. Street and Number  107. Zip Co		10g. Citizen of What Country?
6602 Landing Way 20	785	United States No- 14. Race - American Indian,
Ψ ≔ ⊑	t of Hispanic Origin? (Specify Yes or Cuban, Mexican, Puerto Rican, etc.) No Specify:	Specify:
3 Widowed 4 Volvorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual C	Occupation	Black  16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual C (Give kind of work of life. DO NOT use of life.	done during most of working	
Supervisor P	Special:	Government
To page 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid	dre, Maiden Surname)
E Deroy Howard	Myrtle Dougla	AS mber, City or Town, State, Zip Code)
변경 등 문화 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (S	Street Arlingto:	
Myrtle Andrews / Mother 2441 Nelson  20a. Method of Disposition  20b. Place of Disposition (Name cemetery, crematory or othe		
1 □ Burial 2 🖾 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Metropolitan	aug 21,2010	Alexandria, VA
The part of the pa	Address of Facility Pope Fun	eral Homes, P.A.
Some of the state		tville, Maryland 20747
23a. Part 1. Ther the disease, of complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.		ry arrest, Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death)  Americal Seizure Discourse Transfer of the Condition of the Conditi	rder	
/Medical resulting in death)  Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate caute. Enter Uncertainty Cause (Disease or Injury		
Sequentially list of minimal at the control of the		
dical to earn a series of the physician of the burnels of the purish of		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic predictions of the pregnant at time of death   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic predictions of the predictions of		23d. Date of delivery
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Ves   22   No   No   No   No   No   No   25c. If yes, outcome of pregnancy 1   Live birth   2   Fetal death   3   Ectopic pregnant at time of death   5   Other (spec		Month Day Year
1   Yes 2   No 9   Unknown 9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cau		
Part II. Other significant conditions contributing to death but not resulting in the underlying cau	oo giveiriiri airii	old tobacco use contribute to the cause of death?
s been s should letted		Yes 2 No 3 Probably 4 Unknown
(I) id iii (I)   OL	a	Vas an utopsy erformed? 24b. Were autopsy findings available prior to completion of cause of death?
で デージャン O O O O O O O O O O O O O O O O O O O	1 □ Ye	es 2 No 1 Yes 2 No
25. Was case referred to medical examiner?  Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA	26. Place of Death (Check of Other:	lesidence 6 □ Other (Specify)
The state of the s		ibe how injury occurred
Thatural 5 Pending (Montin, Day, Tear)	1 □Yes 2 □No	
1   Person   1   Inpatient   2   ER/Outpatient   3   DOA   27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Place o		on (Street and Number or Rural Route Number, Town, State)
The standard policy of the best of my knowledge, death occurred at 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at	the time, date and place, and due to	the cause(s) and manner as stated.
28e. Place of Injury - At nome, farm, street, factory, or building, etc. (Specify)  1	n my opinion, death occurred at the ti	me, date and place, and due to the cause(s)
29b. Signature and title of certifier 29c. I	icense number	29d. Date signed (Month, Day, Year)
Salvador Spragter Do H	0055927	Hugest 10, 200
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SALVADOR Sylvator 3 od 450, tol 3	more chever	by Maryland
State Registrar AUG 1 9 2010 2010 32. Registrar's Signature 3. Registra		//

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 13. 2010 rear Ε. Keys 10:33am™ Josephine 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverly Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Hours Min Washington, D.C 578-56-0882 68 Nov. 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Capitol Heights 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 144 Daimler Dr. 20743 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Mental Health Counselor D. C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph N. Handy Bessie Whitley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3120 Bellbrook Ct. Temple Hills, Md. Crystal C. Tyler / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Ft. Lincoln 8/23/2010 4 Donation 5 Other (Specify) Brentwood, Md. 21. Signatur of Funeral Service Lice and Address of Sacility ope. P.A. S Mariboro Pike/ Forestville, Md. 20747 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TATAL disease or condition resulting in death) Due to (or as a consequence of) ontru Due to (or as a consequance of) AB Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No

Physician Medical **Examiner** 

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attending physician for use as the burial-

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After this certificate funeral director, pag

I Director: /

hours after 24 hours

within 2.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Director

Funeral

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Physician/Medical

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Certificate:

Medical

**Examiner** 

**Funeral** 

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items on any injury or other traumatic event. The state of the state of

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

> 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Day

> > 24a. Was an

autopsy perform

Yes

g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pregnant at time of death Unknown

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 🗌 Yes

2 🗌 No

Year

25. Was case referred to medica examiner? 2 XNO 27. Manner of Death

1 Natural

☐ Accident ☐ Suicide

4 Homicide

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 区ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred

1 Tes

2 🗌 No

Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Æ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated  $\mu^3$  Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of 29b. Signature

5 Pending

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p

+105 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 2010 7:18 Рм Michael William Kelly Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 0ct.29, Hours 1 🔀 M 2 🗆 403-64-1957 Kentucky 1945 **Director** Yrs. 64 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Myersville 1 Yes 2 No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21773 USA 11908 Woodland Way Road 12. Was Decedent Ever in U.S. Armed Forces? 14 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 9 Completed by 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates. 68-72 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 4 Elementary/Seconday (0-12) Project Manager Information Technology 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ည Mary Kelly Benjamin of Health and N fitem 27 is ma r other trauma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Barbara J. Ke</u>lly/wife 11908 Woodland Way Road, Myersville, MD 21773 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory Aug. 28, 2010 Hagerstown, Maryland 4 Donation 5 Other (Specify) 504 Main Street Signature of F 22. Name and Address of Facility Myersville, MD 21773 Ricketts Funeral Home 23a. Part Y. Enter the like like, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director.

To the Funeral Director, page 2 should be detached for use as the burneled filled in by the funeral director, page 2 should be detached for use as the burneled. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Registrar DHMH 17 Rev 7/2009

State

29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

w 7th St

400 trar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MOD 70559

Frederick, mb 21701

29d. Date signed (Month, Day, Year)

August 25 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ *20*10 800 AM CHARMAINE JACOUELINE LAWSON Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Prince George's Prince George's Hospital Center Chevery 9. Birthplace (State or Foreign Country) Jamaica Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral 1 🗆 M 2 🗶 Days Hours Min. (Month, Day, Year) 12/06/1969 Director **4**0 none Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1704 Brightseat Raod, 20785 #101 Jamaica 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 X Never Married 2 Married "natural", or Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No 3 Widowed 4 Divorced Specify: Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of Joel Lawson Winsome Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Winsome Reid - mother 1704 Brightseat Road, #101, Hyattsville, MD 20785 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD George Washington Cm 8/21/10 21. Signature of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home eaus 246 N. Washington St. Rockville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Described the shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, Examine if any, leading to immediate

Cause (Disease or linjury Due to (or as a consequence of) equires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burial-t attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 2 No g Unknown 9 Unknown Records, P.O. een signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes, Renal Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has ! autopsy te Yes 2 N To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifice completed filled in by the funeral director. p 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 2 No 1 Yes Inpatient 2 ER/Outpatient 3 DOA ၉ 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28a 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No iniury 5 Pending Investigation Accident A 6 Could not be Suicide Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Griffying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) D2233C leted cause of death (Item 23a) (Type, Print) 30. Name and a 3001 Hospital Drive, Cheverly, MD 20785

State Registrar 31. Date filed Month, Day, Year

AHG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year atherino 11:65 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death inster Westm D 8. Date of Birth
July 31, Year) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral Days Hours 1 M 2 F Maryland Director 81 217-24-1313 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster Maryland Carroll 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 USA 225 Frock Dr. Apt. 315 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8 1 and 2 should be filed with Health and Mental Hygitem 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Barenshaub August Wehrman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Davis/Daughter 1208 Guadelupe Ct., Westminster, MD 21157 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Carpeles Grand Population Polace) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/20/2010 Owings Mills, Maryland Veterans Cemetery 21. Signature of Funeral Service Licensee 27 1115 Trunk Trunk Tally Home and Chapel, P.A. 412 Washington Rd., Westminster, Md 21157 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician, ance tollo-Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Whiknown Completed 24b Were autopsy findings available 24a. Was an prior to completion of cause of death? has perform certificate 2 No 1 Tyes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) HOSPICE examiner? 1 \sum Yes Other: 4 Nursing Home 5 Residence 6 🗶 Other (Specify) 2 **N**0 ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA bue hou Se 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗆 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJL 4+2 who completed cause of death (item 23a) (Type, Print) 30. Name and addre Robert L. Rice, M.D. 31. Date filed (Month, Day, Year) AUG 1 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Year Month Physician/ Glen Leatherman Vestal 1:50P Auq Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospice Dove House Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 1 - 3 - 1 9 1 9 1**X** M 2 □ F Hours 91 **Director** 232-26-0833 Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hart: If item 22 is marked outher than "natural", or items 23a or 28a-f show jury or orber traunatic event, the Medical Examiner must be notified at jury or orber traunatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director MD Carroll 1 🗌 Yes 2🔀 No Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 212 Snowfall Way 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married ☐ Yes 2 🙀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specifywhite 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dillion Leatherman Grace Whiteman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Snowfall Way, Dorothy Leatherman-wife Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 Surial 2 Cremation 3 Removal from State Evergreen Memorial 8/13/10 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of the ral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home Ε. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ancreatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine us to for as a nonsequence of cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been signed by templeted filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec rice 24 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e p0059943 2010 WJL 30. Name and address of pason who completed cause of death (Item 23a) (Type, Print) 10 onn e 307 295 Stoner 31. Date fled (Month, Day, Year) 32. Redistrar's Signature State

Registrar

AUG 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death LAMBERT 2150 M Physician/ VIVIAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. uneth, 21 1 M 2 F Year 939 Maryland 216-36-2238 71 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho, amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 Tes 2X No Marv1and Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 130 Hearne Rd. Apt 1015 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: B1ack 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Crownsville Elementary/Seconday (0-12) College (1-4 or 5+) Dietary Inspector 12th Hospital 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Marie Johnson Eugene Haste Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Bay Green Dr. Carlos Wallace(Son) Arnold, Md. 21012 20a Method of Disposition 20b. Place Disposition Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 8-19-10 Memorial Park Annapolis, Md. 4 Donation 5 Other (Specify) Windows Record Scill Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee MO048 West St. Annapolis | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and sthe burial-transit Cause (Disease or linjury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) 1 ☐ Live Birth 2 ☐ Fetal geal 4 ☐ Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Year Month as been signed by the 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy page performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) funeral director, examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 20 3 ed cause of death (Item 23a) (Type Print) egistrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death August 12 Day 2010 Year Physician/ рМ Gladys Louise Lewis 5:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 □ M 2 1 F nonth, Day, Days Min Director 73 T937 Franklin, Va. 224-50-1930 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ¥ Yes 2 □ No Maryland Prince Georges Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 804 Owens Rd. 20745 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛛 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7.8 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) SUPERVISOR GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doc Bradshaw, Sr. Annie Milan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Owens Rd. Oxon Hill, Md. William Lewis, Sr. / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Harmony Memorial 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/20/2010 Landover, Md. 21. Signature of Funeral Service Life 22. Name and Address of Facility Alexander S. Pope Prairestville, Md. MO1085 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ABDOMINAL COMPARTMENT SYNDROME Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DISSEMINATED INTRAVASCULAR COAGULATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): OLIGURIC RENAL FAILURE death certificate be executed the burial-tran and that initiated events Due to (or as a consequence of resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No p Month Year Pregnant at time of death 5 Other (specify) 9 Unknown the g Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t 24 hours after death.

Letteral Director: After this certificate has been sign the principle of the funeral director, page 2 should be ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) was case relative to examiner?
1 ☐ Yes 2 📈 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ပ tX☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b City or Town, State) Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D41752 AUGUST 12, 2010

CR 5

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 9 2010

32. Registran's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

BRIDGET SCHOELLMAN 1500 FOREST GLEN ROAD SILVER SPRING MARYLAND 20910

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State of Ma	ryland / Depa <i>Cer</i> i	artment of He <i>tificate of De</i>		ntai Hygier Reg. i	2010	27682
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			2.1	Date of Death		3. Time of Death
	Medic Examin	al	James William  4a. Facility Name (if not institution, give street and number)	Lancaster	Jr. 4b. City, Town, or Lo		ugust 14	2010 Pear 4c. County of Death	16:47 P M
	Examin		Southern Maryland Hosp		C1:	inton			George's
	Funeral Director		5. Social Security Number  579-42-6631  6. Sex 1 № N 2 □ F  7. Age	(In yrs. last birthday) 76 Yrs.		If Under 24 Hrs. 8. ( Hours Min. Ap	Date of Birth (Month; Day6Year YIII; 26°,	9. Birt	hplace (State or Foreign IntMaryland
			Usual Residence of Decedent	10c, City, Town or Loc	cation				10d. Inside City Limits
	farylan 8a-fsh tified a	ecto	Maryland Prince George's	,,		Suitland			1 🏿 Yes 2 □ No
	h the N 3a or 2 be no	al Di	10e. Street and Number		10f. Zip Code	2071/		Citizen of What Co	
	ems 2	Funeral Director	4118 Maple Road  11. Marital Status 12. Was Decedent Ex	ver in U.S. 13. V	Vas Decedent of Hisp	20746 anic Origin? (Specify	Yes or No-	nited Sta	rican Indian,
2-003p	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Unportment of Health and Mental Hygiene. In an artical stranger is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 1 Yes 2 New 2 If Yes, Give Year or Dates.	Jo.	Yes 2 ANO	Mexican, Puerto Rica Specify:	in, etc.)	Black, White B1	ack
12-CL	72 hou n "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupation  kind of work done dur.  NOT use retired)	on ing most of working	16b	. Kind of Business	industry
717	within giene. ier thai the N		Elementary/Seconday (0-12) College (1-4 or 5-12)			ice Office	r	Govern	ment
and	ntal Hy red oth eed oth	To Be	17. Father's Name (First, Middle, Last)  James Lancaste	r, Sr.	1	8. Mother's Name (Fir		en Surname) E. Adams	
Maryland	hould band Me is mark umati		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and	d Number or Rural Ro	ute Number, City	or Town, State, Zip	Code)
oʻ.	and 2 s lealth em 27 ther tra		Mattie Lancaster/ Daughter  20a. Method of Disposition	4118 20b. Place of Dispos	Maple Road	d Suitlan	d, Mary	Land 207  Location - City or	
Ž E	Page 1 nent of I nt: If it		1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify)	cemetery, crem	natory or other place) on Nationa etery	15, 20	ber	-	n, Virginia
Baltimore,	permit. F Departm Importa any inju		21. Signature of Funeral Service Licensee	cal Home,					
			23a. Part Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente	er the mode of dying,	such as cardiac or res	spiratory arrest,		Approximate Interval Between
P	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	conseque of):	archal	ntant	n		Onset and Death
	Examiner			consequed on.					
=	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	consequence c'):					
	ate be executed ohysician and the burial-transi	l Exa	that initiated events C.	consequence of):					
		edical	d						
20 X 08	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	In the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
л. О	hat the ed by th detache	by Phy	Part II. Other significant conditions contributing to death but	ut not resulting in the u	Inderlying cause giver	n in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ds,	quires ; en sign						1 🗌 Yes		robably 4 Unknown
Vital Records,	To the Hospital or Attending Physician: The law requires that within 24 hours after death.  To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det	Completed					24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of
Ita	sician: certific irector,	Be	25. Was case referred to medical example?  1 Yes 2 No  Hospital:  1 Inpatie	ent 2 ER/Outpatier	Tau.	e of Death (Check onl		6 Other (Spec	(6.)
n of	ding Phy th. After this funeral d	cate: To	27. Man of Death  1 Natural 5 Pending 2 Accident Investigation	y 28b. Time of	28c. Injury a work?		. Describe how in		
Division of	I or Atter after dea Director d in by the	Certificate:	2 Suicide 6 Could not be	ry - At home, farm, stre . (Specify)	eet, factory, office	28f.	Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	e Hospita 124 hours e Funeral bleted fille	Medical	29a. Certifier (Check 2 Medical 50 yiner: On the basis of exceptions)	ramination and/or invest	tigation in my opinion	death occurred at the	time, date and pla	ace, and due to the	cause(s) and manner stated.
	vithii To th		29b. Signature and title of certifier		29c. License r	number	29d.	Date signed (Mont	h, Day, Year)
12	- 6		30. Name and address of person who completed cause of de Ri www www www www www.	eath (Item 23a) (Type, F Southern Signate	Print)  Recove St	E Soute 31D 1	Was hour	andc 200	23.
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registra	Signat e	,		7		

10-05956 Jesus Miranda Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

sus Miranda		State of Maryland / Department 1-For State		nd Mental H		201	n 27683
Dhorini		Registrar  1. Decedent's Name (First, Middle,Last)	Orbeatti		Reg	j. No. 20	3. Time of Death
Physici edical Exami						Day Year	0817 hrs
· .		4a. Facility Name (if not institution, give street and number)	4b. City. Town.	or Location of Deat		4c. County of [	Death
		1900 Chapman Avenue	Rockville			Montgome	ery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	y) If Under 1 Ye	ear If Under 24Hr	s. 8. Date of Birth	(MM/DD/YYYY)	9. Birthplace (State or
Director			Months Da	ays Hours Mir	,	F	oreign Country) Cuba
			Yrs.		June /	, 1939	country/ Cuba
à		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L.	ocation				10d. Inside City Limits
W 81		MD Montgomery Rockvil					1 X Yes 2 No
/land -f sh	tor	8 7			Lac	0111 111 Pr 1	
Mary r 28a	Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of What	Country?
r death with the Maryland or items 23a or 28a-f show any must be notified at once,		1709 Crawford Dr.	2085			nited St	
h wil	era	11. Marital Status 1 Never Married 2 Married Armed Forces?	Was Decedent of H If Yes, specify Cub			14. Race - A White, e	American Indian, Black, etc.
or it	Funeral	1 X Yes 2 No			Cuban		White
s afte ral", tiner	þ	3 Widowed 4 Divorced of Param 1		NO Specify.		Specify:	
hour matu Exan	pe	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Education (Specify only highest grade completed)	edent's Usual Occup ng most of working li			16b. Kind of Busin	ness/industry
36 n 72 n an lical	plet	Elementary/Secondary (0-12) College (1-4 or 5+)					
with with giene Med	Completed	17. Father's Name (First, Middle, Last)	Bus	Driver	e (First, Middle, Ma		ry County
filed Hyg		Salustiano Miranda					
112 Id be Menta nark	o Be		ailing Address (Str	BLan	ica Hern	andez	State Zin Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Ĕ						
and 2 ealth ealth			0 14th St sposition (Name of c			20c. Location - Ci	
Ore of H If it		1 Burial 2 Cremation 3 Removal from State crematory of	or other place)				•
Pag ment tant:		4 Donation 5 Other Specify: Ft. Line	coln Crem				d, Maryland
Salt ermit epart npor njury		21. Signature of Funeral Service Licensee M01463	22. Name and Addre	U	imple Tr		
			1040 Roc	kville Pi	ke, Rock	ville, M	
Physician Medical		23a. Part II. Enter the disease, or complications that caused the death. Do not en failure. Wish only one cause on each line.	ter the mode of dyin	g, such as cardiac o	or respiratory arres	st, snock, or neart	Approximate Interval Between Onset and
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		or condition resulting in death)  Due to (or as a consequence of):					
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	nin	cause. Enter Underlying Cause (Disease or injury that initiated					
D = =	Examiner	events resulting in death) Last  Due to (or as a consequence of):					
ox 68760, ant certificate be executed attending physician and for use as the burial - transit	alE	d					
be ex urial	dical	UNPENDED					
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certif	iar	past 12 months?    1   Live birth   2   4   Pregnant at time of death   5	Fetal death 3 Other (Specify)	Ectopic pregn	ancy	Month	Day Year
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Vital Records, P.O. Bo. hysician: The law requires that the deal this certificate has been signed by the at a director, page 2 should be detached for		Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause	e given in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
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ds,	Completed				24a. Was ar		re autopsy findings available
COI law has be 2 sh	Idu				autopsy perform	ned? dea	
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Division of Vital Records, ral or Attending Physician: The law require is after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner? Hospital: 4 Inspital: 4		Other Nursi			24h C
f V  Phys er this	T <sub>0</sub>	1 Yes 2 No ruspital 1 Inpatient 2 ER/Outpat  27. Manner of Death 28a. Date of Injury 28b. Time		jury at Work?		esidence 6 🗹	Other: Scene
n of ding Pl h. After funera	Certification:	1 Natural 5 Pending FOUND: Pay, Year) FOUND:		Yes 2 ✓ No	Operator of b	icycle in collis	sion
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JVI I or after	III.	3 Suicide 6 Could not be determined (Specify) Parking Lot	street, ractory, onice	e building, etc.	or Town, Sta	ite)	or Rural Route Number, City
Sepits hours inera y fille		4 Homicide				Avenue, Rocky	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the bi	Medical	Certifying Physician: To the best of my knowledge, death of one)     Wedical Examiner: On the basis of examination and/or invest					
To t with To t	Ned	and manner stated.  29b_Signature and title of certifier		nse number			(Month, Day, Year)
aul	~	Do O		C.M.E.	1	August 9, 20	
941		Tothi Cen - Tolla	0.0	√. (V). ∟.		August 9, 20	
		30. Name and address of person who completed cause of death (Item 23a)	r 111 D (	Stroot Dalking	ro MD 24204		
		Patricia Aronica-Pollak MD. Assistant Medical Examine		Street, Baltimo	E, MID 2 1201		
St Regis	tate	31. Date filed (Month, Day, Year) 22. Registrar's Signature	Part.				

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please Type or Print in Black			-	_	
		•	Tregion of	ertificate of			ene eg. No.2	27684
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Melvin Martin			2. Date of Death Month August	Day Year 16, 2010	3. Time of Death O1:58 PM
-military	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, o	or Location of Death	0.0000	4c. County of Death	
			1718 Dunn Swamp Road  5. Social Security Number 6. Sex 7. Age (in yrs. last birthday)	Pocomol If Under 1 Year		0. 0.4( 0.4)	Worcester	
ethe-	Funeral Director		228–24–1133   1   X M 2   F   Roo   F   80   Yrs.	Months Days		8. Date of Birth (Month, Day) 3/11/19	Year) Sou Viro	nplace (State or Foreign ntry) jinia
	is filed within 72 hours after death with the Maryland trail Hygiene. so dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	or	10a. State 10b. County 10c. City, Town or I	.ocation				10d. Inside City Limits
	Maryla 28a-f	Funeral Director	MD Worcester Pocomoke	City				1 ☐ Yes 2X No
	a or be no	Ξ	10e. Street and Number	10f. Zip Code		10	0g. Citizen of What Coι	intry?
	th wit ns 23 must	ner	1718 Dunn Swamp Road	2185			USA	
10	r dea		Armed Forces?	. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
036	safte ral", c Exarr	q pe	1 ☐ Never Married 2 ☐ Married 1 ☐ Xes 2 ☐ No If Yes, Give Year or Dates. Army	1 ☐ Yes 2 🗵 No	Specify:		Specify: wh	ite
5-0	hour fnatu	olete	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occup	pation during most of work	ng T	16b. Kind of Business In	ndustry
121	within 72 hours after death with the Maryland gjene. ner than "natural", or items 23a or 28a-f sho ner than "natural", or items 2a or 28a-f sho t, the Mediral Examiner must be notified at	Completed by	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)			C 3	
d 2	filed wit al Hygie d other event, th	امها	7 wate:	man	18. Mother's Nam		seafood	
lan	should be file and Mental   7 is marked c raumatic eve	힏	Melvin Martin		Minnie S		aiden Surnamej	
ary	hould and M s mai			ling Address (Street			City or Town, State, Zip	Code)
Σ	nd 2 sealth an 27 i		Carol Rantz (daughter) 1718	Dunn Swar	mp Rd., Pa	ocomoke (	City, MD 21	851
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve	la ta	20a. Method of Disposition  1	ematory or other place	rce) i		20c. Location - City or Toak Hall, V	
Balt	permit. Decart Import any inj		21. Signature of Funeral Service License	Tolloway 107 Vine	Funeral Ho Street. P	ome, Prof	essional Asso City, MD 2	ciation 1851
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician/		Immediate Cause (Final	.01				Onset and Death
تحريب	Medical Examiner		disease or condition resulting in death)  Bladder Cane  Due to (or as a consequence of):	× 4				yeter 3
	Lammer	P	Sequentially list conditions, b.					
	ed sit	Examine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury					
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Box 68760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medic	IF FEMALE:					
9 ×	tendir tendir	an/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3		су		23d. Date of deliv	*
Bo	e deat the at ned fo	ysic	1  Yes 2 No 4 Pregnant at time of death 5	Other (specify) _			Month	Day Year
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ord	v requ	Completed by				24a. Was an		ppsy findings available
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ta	rsician: The law is certificate has b	Be C	25. Was case referred to medical examiner?	26. P	lace of Death (Check		12 100	
Ž	Physical this ceral dire	욘	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati  27. Manner of Death 28a, Date of injury 28b, Time		4 L Nursing Ho		nce 6 Other (Specif	y)
0 0	ding F h. After funer	ate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury	work		28d. Describe how	v injury occurred	
sio	I or Attending after death. Director: After I in by the funer	Certificate:	2			28f. Location (Stre	eet and Number or Rura	l Route Number.
Division of Vital Records,	al or A		building, etc. (Specify)			City or Town,		,
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or inve	occured at the time	e, date and place, an	d due to the cause the time, date and	e(s) and manner as stat	ed. ause(s) and manner stated.
	ithin 2 orthe l	ž	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier		ne time, date and plac	e, and due to the c		tated.
	F 3 F 8		165 fells m.s.		63835		03/17/201	
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			-11/1201	<u> </u>
B	N2+1		Vladimir I OFFE, ZOC E.	Vine S	St., Sa	isbury.	MD 218	04
	Stat	re	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	St., Sa	7/		
DHI	Registra MH 17 Rev 7/20	_	AUG 1 9 2010 Janua &	parke				
יורט	1 1 NOV 1/20	,09	ORIG	INAL				

			Amended Item 10	ase Type or bb per F.I State	<b>Print in</b> 0, 08/17 of Marylan				ure A will and N	<b>All Copie</b> Mental Hy	s Are	e Legil	ole.		
	Physicia Medic		State Registrar  1. Decedent's Name (First, Middle RTCHA		LING N	Cer MEHRIN	<b>rtificate of l</b>	Death		2. Date of De Month August	Reg. No eath		ín (	276 3. Time of Dear 9:13 P	
and the second	Examir	er	4a. Facility Name (if not institution Frederick Me 5. Social Security Number	n, give street and nui		last hirthday)	4b. City, Town, o Frede	erick		O Data of Bi		County of	eric		
~	Funeral Director	ì	218–10–8124 Usual Residence of Decedent	1 <b>№</b> M 2 □ F	91	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da Mar 2	ay Year)	919	Mary	ace (State or For Land	eign
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	≝	Maryland Fred  10e. Street and Number	lerick	10c. City, Town or Location			Keyr	mar		10g Ci	itizen of Wh		od. Inside City Lir	
		ı — ı	11904 Simpsons	Mill Road				217	757		109.01		USA		
9000							If Yes, specify Cuban, Mexican, Puerto Rićan, etc.)					14. Race - American Indian, Black, White, etc. Specify: White			
Maryland 21215-0036		Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+) 5+			(Give kind of work done during most of working life. DO NOT use retired)  Doctor				1	16b. Kind of Business Industry  Denistry Dentistry			:ry	
yland			17. Father's Name (First, Middle, Harold Seiss Me					18. Moth Eth	er's Nam nel I	e (First, Middle, Hively	, Maiden	Surname)			
			19a. Informant's Name/Relations Marell Mehring			1190	ng Address (Street  4 Simpson				ymar	, MD	2175	57 	
Baltimore,			20a. Method of Disposition  1 ▼ Burial 2 □ Cremation  4 □ Donation 5 □ Other (	Specify)	. 0	emetery, crer inity	osition (Name of matory or other place Lutheran	Cem	8/18		Та	neyto	wn,	MD	
Bal	Depar Depar Impor any ir		21. Signature of Funeral Service	Licensee	Jam	$\rightarrow$ $\begin{vmatrix} 22 \\ 1 \end{vmatrix}$	2. Name and Addre	ss of Facilit	y Mye e St	ers—Dur , Taney	bora town	w Fun , MD	eral 2178	Home 37	
	Medical Examiner		23a. Part 1 Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on e	ach line.	) LAC 1	er the mode of dyin		cardiac o	or respiratory a	rrest,			Approximate Interval Between Onset and Death	
.09	ate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	с	(or as a consequ										
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  Within 24 hours after death.  To the Luneral Director: After this certificate, has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 ☐ Live 4 ☐ Preg	ic. If yes, outcome of pregnancy  1						23d. Date Monti		y Day Year		
ds, P.O.	luires that the dea en signed by the a uld be detached f	þ	Part II. Other significant conditi	ons contributing to o	leath but not res	sulting in the u	underlying cause giv	ven in Part	l.					cause of death?	
Division of Vital Records,	The law equire cat has been si page 2 should	Completed								24a. Was auto perfo 1  Yes	psy ormed?	prid dea	re autops or to com ath? I Yes 2	sy findings availa pletion of cause 2  No	ble of
/ita	sician: certifi	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 📉 No	Hospital:	Inpatient 2 X	EB/Outpation	Oth	ace of Dear		only one) me 5 ☐ Resi		.П.	2 (1)		
on of \	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, pege 2	Certificate; T		28a. Date (Mori igation		28b. Time of injury	28c. Injur work	y at		28d. Describe I			<i>Specify)</i>		
Divisi	vital or Att urs after de ral Directe illed in by t		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place build	ng, etc. (Specify		eet, factory, office			28f. Location ( City or Tov	wn, State	) 			
	he Hosp in 24 ho he Fune pleted fi	Medical	(Check 2 Medical I	g Physician: To the b Examiner: On the ba g Nurse Practioner:	sis of examination	n and/or invest	tigation, in my opinic	on, death oc	ccurred at	the time, date a	and place	, and due to	the caus	se(s) and manner s	stated.
	. Th		29b. Signature and title of certifie				29c. License	e number	78		29d. Da	te signed (A	Nonth, Da		
	5 tiva		30. Name and address of person Vivian Dech		se of death (Item			rede	ric	k, mi	2 31	703			
ı	Star Registra	~	31. Date filed (Month, Day, Year) AUG 1		legistrar's Signat		back								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State State Registrar	of Maryland / Depa Cer	artment of Healtl tificate of Death		ntal Hygier Reg.	71111	27686
	Physicia		Decedent's Name (First, Middle, Last)  Lou Dean Moore				Date of Death Month	Day 2010 Year	3. Time of Death 10:00 a M
	Medic Examin	_	4a. Facility Name (if not institution, give street and in 505 High Acre Drive Unit	number) it T17	4b. City, Town, or Locatic	on of Death		4c. County of Dea Cari	coll
τ.	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M	7. Age (In yrs. last birthday)	If Under 1 Year If Und Months Days Hour	der 24 Hrs. 8. rs Min. N	Date of Birth (Month Day, Yea OV 16,	9. B	irthplace (State or Foreign ountry) Jaho
	Ba-f show		Usual Residence of Decedent  10a. State 10b. County  Maryland Carroll	10c. City, Town or Lo	cation Westn	ninster			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	23a or 28 sst be not	Funeral Dir	10e. Street and Number 505 High Acre Drive Un	it T17	10f. Zip Code	 21157	10g.	Citizen of What C	
036	permit. Fage I and 2 should be likely writin 12 hours after death with the way and broad-ment of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married 1 Yes,	Forces? es 2 No	Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 🛣 No Spec	ican, Puerto Rica	Yes or No- an, etc.)	14. Race - Am Black, Wh Specify: W	
Baltimore, Maryland 21215-0036	thin 72 hour sne. than "natur he Medical	Completed by	15. Decedent's Education (Specify only highest grade comple Elementary/Seconday (0-12) Colleg	ted) (Give	dent's Usual Occupation kind of work done during n O NOT use retired) Civil Servar		I	o. Kind of Busines	·
and 2	be med will ental Hygie ked other ic event, the	l as l	17. Father's Name (First, Middle, Last) Leo Linford Reddish		18. M		rst, Middle, Maid ckett	len Surname)	
Mary	alth and Maland Maland III is mar		19a. Informant's Name/Relationship (Type, Print) Kay Labare, daughter	19b. Maili 112(	ng Address (Street and Nur )6 Tardley Ct	mber or Rural Ro	oute Number, City Sville, I	y or Town, State, 2 MD 21754	Zip Code)
imore,	rage I and nent of Hes ant: If item ury or othe		20a. Method of Disposition  1   Burial 2 □ Cremation 3 Removal f  4 □ Donation 5 □ Other (Specify)	rom State 20b. Place of Dispo cemetery, crea Lund Cen	matory or other place)	8/19/2	010	Lund, Id	aho
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee	2 9	2. Name and Address of Fa 1 Willis Str	eet, Wes	ers-Durb stminste	oraw Fun er, MD 21	neral Home 157
لمهب	Medical Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events C.	e to (or as a consequence of):  e to (or as a consequence of):  e to (or as a consequence of):	a / COPD				Interval Between Onset and Death
Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	, outcome of pregnancy Live Birth 2 ☐ Fetal death 3 l Pregnant at time of death 5 l Unknown	Ectopic pregnancy Other (specify)			23d, Date of o	delivery Day Year
s, P.O.	res that the signed by d be detac		Part II. Other significant conditions contributing		underlying cause given in F	Part I.			to the cause of death?  Probably 4 □ Unknown
Division of Vital Records,	ine law requisate has been page 2 shoul	Completed by	ty patenson	<i>30</i>			24a. Was an autopsy performer	prior t	autopsy findings available o completion of cause of ? /es 2 \( \square\) No
/ital	s certific lirector,	To Be	25. Was case referred to medical examiner?  1  Yes 2  Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatie	Othori	Death (Check or		e 6 🗆 Other (Sp	ecify)
n of \	th. : After this e funeral c		27. Manner eath 28a. I	Date of injury Month, Day, Year)  28b. Time of injury		280	d. Describe how i		
Divisio	al or Atter s after des il Director ed in by the	Certificate:		Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28	f. Location (Stree City or Town, S		Rural Route Number,
	ne Hospita in 24 houra he Funera pleted fille	Medical	(Check 2 Medical Examiner On the	the best of my knowledge, death e basis of examination and/or inve ner: To the best of my knowledge	stigation, in my opinion, dea	ath occurred at the	e time, date and p	place, and due to th	ne cause(s) and manner stated
	WITH SOUTH THE THE THE THE THE THE THE THE THE T		29b. Signature and title of certifier	6	29c. License numb		29d	S \ I G	nth, Day, Year)
	20		30. Name and address of person who completed FRNESTO MENDOLA	cause of death (Item 23a) (Type, 3 L 6 WASH (NOTO 32. Registrar's Signature	Print) J ROAD SUITE	120, W	ESTMINST	ER, MD.	21157
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 17 2010	32. Registrar's Signature	parke				

ok per D. B.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 0 27687 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hazel Malady 9<sup>ay</sup> 2010<sup>ar</sup> Louise Aŭgust 4:45am м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Fairhaven Health Care Center Sykesville Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TYP Months Hours Min Country) March Day 22ar) 177-24-9669 79 PA **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Carroll Sykesville 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 7200 Third Avenue 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married ۵ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Judson Kelly Gertrude Burley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7492 Windswept Ct., Sykesville, MD 21784 Mrs. Sharon Feldman (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 X Removal from State Blair Mem. Park 8/16/2010 4 Donation 5 Other (Specify) Bellwood, PA 21. Signature of Funeral Service Licensee, PO Box 195 Sykesville, MD 21784 CHAPEL, PA MO0764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Schemic Medical resulting in death) Examiner cardiom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) ō in the past 12 months? Month Day Year be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, The law requires 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' this certificate 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; I 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

WJL

Registrar

DHMH 17 Rev 7/2009

State

(Check

only one

31. Date filed (Month, Day, Year)

AUG 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 27688 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ August 2010 3:55 p Virginia Myrtle Merkel Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Westminster 715 Holliday Lane 8. Date of Birth (Month, Day, Year Dec 13, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Min. Mary land 1 M 250 Months Director 93 213-03-9423 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Westminster MD Carroll 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe 23a Funeral USA 715 Holliday Lane within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Year or Dates. altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 ₩ Widowed 4 Divorced White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) own home Homemaker 12 permit. Page 1 and 2 should be filed win Department of Health and Mental Hygie Important: if item 27 is marked other any injury or other traumatic event, to once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Myrtle Shipley Wilber Vaughn Bossom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hampstead, MD 21074 195 Phillips Drive Kenneth B. Merkel 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Pikesville, Maryland Druid Ridge Cemetery 8/16/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facili Pritts Funeral Home & Chapel, PA Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused th Approximate Interval Between shock, or heart failure. List only one caus Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed tra that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Li recal Co.

Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: performed? Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be examiner? Hospital: 2 🔼 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier WIL nd address of person who completed cause of death (Item 23a) (Type, Print) 6 MD 31, Date filed (Month, Day, Year) 32. Re State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month James Kevin Malloy 15 2010 4:50 Рм August 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 01/04/1936 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex Social Security Number Hours Months Days Washington, D.C. 1 ₹ M 2 □ F 74 578-48-3248 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2 🕅 No Anne Arundel Edgewater Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21037 3874 Twin Oaks Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Real Estate Real Estate Developer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anastatia McGrath John James Malloy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3874 Twin Oaks Road, Edgewater, Maryland 21037 19a. Informant's Name/Relationship (Type. Print) Barbara A. Malloy/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 08/17/2010 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 21. Signat And Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lim. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) quence of): neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

attending physician and for use as the burial-transit

been signed by the should be detached

certificate has be irector, page 2 st

funeral director,

After this

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

6P

To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

**Examiner** 

10a. State

Director

Funeral

Completed by

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, its Madical Eveninger rust be notified a once.

Baltimore, Maryland 21215-0036

Physician/Medical \$ Completed

Examiner 25. Was case referred to medical examiner? Be Medical Certification: To 27. Manner of Death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

1 Yes 2 No

Natural 2 ☐ Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performe 1 ☐Yes 2 No 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 5 ☐ Pending investigation Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

De04337

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe

250 ( Medical Pken MA

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Depart	icate of Death		2010 27690 27690	
	Physicia		Decedent's Name (First, Middle, Last)  John Henry Medlock		2. Date of Death Month	17, Day 2010 Year 3. Time of Death 13:11 M	7
	Medic Examin			o. City, Town, or Location of Dec	eath	4c. County of Death	┨
كجس			Washington Adventist Hospita1  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Takoma Under 1 Year I If Under 24 H		Montgomery  9. Birthplace (State or Foreign	╛
Ī	Funeral Director		578-26-9764 1 X M 2 F 83 Yrs. MG	onths Days Hours Mi		Year) 1927 Country) DC	
	show d at	tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location	on		10d. Inside City Limits	1
	e Mary 28a-f notifie	)irec	Maryland Prince George's		far1boro	1 🏻 Yes 2 🗆 No	┙
	vith the 23a or st be	Funeral Director	10e. Street and Number 13706 New Acadia Lane	Of. Zip Code 20774	. 1	Og. Citizen of What Country?  United States	
	ould be filed within 72 hours after death with the Maryland did Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "matic event, the Medical Examiner must be notified at			Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.	1
21215-0036	ırs after ıral", o I Exami	ed by	1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced 1 Yes, Give 1 Year or Dates.	Yes 2 No Specify:		<sub>Specify:</sub> African American	
2-	72 hou n "natu ledica	Completed	15. Decedent's Education 16a. Decedent's (Give kind (Gi	's Usual Occupation of work done during most of w OT use retired)	vorking	16b. Kind of Business Industry	1
212	within giene. er tha			ministrative O	fficer	Government	
Maryland	e filed ntal Hy ed oth event:	To Be	17. Father's Name (First, Middle, Last)  Benjamin Medlock	18. Mother's N	Name <i>(First, Middle, M</i> <b>Willi</b>	•	
äŽ	should be and Me	·		ddress (Street and Number or I			$\dashv$
	□ = 2 ± □		Hannah Rebecca Medlock/ Wife 13706	New Acadia Lan			
nore	0		20a. Method of Disposition 1	n (Name of ry or other place) Aug Memorial 201	gust 28,	20c. Location - City or Town, State  Landover, Maryland	
Baltımore,	permit. Page Department of Important: If any injury or once.					neral Home, Inc.	1
_	<u>σ</u> □ = α ο		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the	1 Benning Road e mode of dying, such as cardi			1
F	nysician/		shock, or heart failure. List only one cause or ach line. Immediate Cause (Final disease or condition	o Imenorus	w Des	Interval Between Onset and Death	1
	Medical Examiner		resulting in death)  a. Due to or as a cusequence of):	Colon 1	Cama	1	7
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):		Lacrice	1	1
	executed an and rial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last				-
2	ificate be executed ig physician and as the burial-transit	fedical l	d				
09/89	ertificat ding ph	_	I E EEMALE:				7
X Q Q	To the Hospital or Attending Physician: The law requires that the death certivation 24 hours after death.  To the Luneral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a completed filled in by the funeral director, page 2.	Physician/	23b. Was decedent pregnant in the past 12 months?  1	topic pregnancy her (specify)		23d. Date of delivery  Month Day Year	
5	at the c d by th letache			rlyina cause given in Part I.	23e Did tob	pacco use contribute to the cause of death?	$\dashv$
7. 7.	uires th in signe uld be c	ed by	Dools lan Yhumhia	S		es 2 No 3 Probably 4 Unknown	
Vital Records,	law req as bee s 2 sho	Completed			24a. Was an	y prior to completion of cause of	1
Ye	n: The ificate h	e Cor	25. Was case referred to medical	26. Place of Death (C/	perform 1  Yes 2		4
VITA	ysicia is cert direct	To Be	examiner? 1   Yes 2   Yo   Hospital: 1   Hospital: 2   ER/Outpatient 3	Other:		nce 6 Other (Specify)	
n or	ding Pl h. After th funeral		27. Manner of Death  1 Natural 5 Pending  28a. Date of injury (Month, Day, Year)  28b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe hov	w injury occurred	
DIVISION	r Atten ter deat rector: by the	Certificate:	2 Accident Investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined   28e. Place of Injury - At home, farm, street, building, etc. (Specify)		28f. Location (Str. City or Town,	reet and Number or Rural Route Number,	+
Ś	pital or burs aft eral Dir filled in			ured at the time date and place	2	·	-
	he Hos in 24 h he Fun pleted	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	ion, in my opinion, death occurre	ed at the time, date and	d place, and due to the cause(s) and manner stated	d.
	Vith To th		29b. Signature and title of certifier	29c. License number	1-Mn 25	9d. Date signed (Month Day, Year)	7
	سر		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 3014	TIDL	0 118 2010	$\dashv$
	_ 5		DR. NASREEN KANED 7701 CI		E. TAKO	MA PAIK MD. 2091	2
	Stat Registra	e	31. Date filed (Month, Day, Year)  AUG 2 0 2010  August 19 32. Registrary Signature				

10-06354 Ronald McNutt

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2010 2769	2	0		0	2	7	6	9	
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		1- For State Certificate of De	eath	Reg	g. No.	21001
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
Medical Exami		RONALD L. MCNUTT		Month August 23,		0056 hrs
	,	4a. Facility Name (if not institution, give street and number)  4b. C	City, Town, or Location of De	ath	4c. County of Death	
			arve de Grace		Harford	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Under 1 Year If Under 24	Hrs. 8. Date of Birth	n(MM/DD/YYYY) 9. Bir	thplace (State or
Director		212-28-6390 <sub>1VM 2</sub> 80 <sub>Yrs.</sub> N	onths Days Hours	win. 07/24	/1930 Foreig	untry) MD
any	- 1	Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location	<del></del>			10d. Inside City Limits
						1 Yes 2 No
Maryland 28a-f show d at once.	힏	MD Harford Darling	f. Zip Code	110	g. Citizen of What Cou	ntry?
Mary 28a	Director	100. Galact and Transpor		"		
th the Maryland 23a or 28a-f sho notified at once.		4426 Conowingo Road	21034			USA
ms 2	Funeral		ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	( Specify Yes or No- erto Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
death or ite	[5]	1 Yes 2 X No			7.7	ما د ما
after al", o	3	or Dates:	s 2 X No specify:			hite
ours			Isual Occupation (Give kind If working ills, DC NCT uss		16b. Kind of Business/	Industry
72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	_		Civil S	ervice
03( ithin ne.	립	12 Fire	ighter			ervice
5-0036 led within 72 hours a Tygiene. other than "natura the Medical Exami		17. Father's Name (First, Middle, Last)		ame (First, Middle, M		
21 be fill ntal I rked ent,	Be	Lee Earl McNutt	B C C C C C C C C C C C C C C C C C C C		lma Bisho	
ould Med J Med	ျ		dress (Street and Number			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28æ-f sho injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u>			Conowingo		rlington	, MD 21034
e, land Heal Heal		20a. Method of Disposition  20b. Place of Disposition  crematory or other p		Date	20c. Location - City or	Town, State
imore Pages 1 ment of F. lant: If i		Darlingto		/27/2010	Darling	ton, MD
Baltimore, permit. Pages I an Department of Hea Important: If iter		4   Donation 5   Other Specify.   //	and Address of Facility			
Balt permit. Depart Impor			kins Funera	1 Home,	Inc.,Del	ta, PA 🚽
Physician		23a. Part I. Enter the disester, or complications that caused the death. Do not enter the m failure. List only one cause on each line.				Approximate Interval
/Medical		Live - steventure Athenne of exotic Cordinus	secular Disassa			Between Onset and Death
`Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	isculai Disease			1
		h				
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):				
	ᆵ	cause. Enter Underlying Cause (Disease or injury that initiated				
i e chi	Examine	events resulting in death) Last Due to (or as a consequence of):				
760, frozte be executed g physician and the burial - transit	a	d				
), be ex ician urial	/Medical	UNPENDED AMENDED				
760 icate phys	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b, Was decedent pregnant in the	2 Teterio pro		23d. Date of deliver Month	y Dav Year
68' certifi ding				griancy	Wioriai	Day (Cui
OX eath (	sic	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)			
b. B the d	Physician	Part II. Other significant conditions contributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
P.C that that deta	by			1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
S, quires en sig ald be	Completed		· · · · · · · · · · · · · · · · · · ·	24a. Was a	an   24b. Were a	utopsy findings available
Ord w reg	ble		<u> </u>	autops perfor		completion of cause of
Che la	티			1 ✓ Yes 2		es 2 No
al R an: 1	ധി	25. Was case referred to medical	26.Place of Death (Che	eck only one)		
Vita ysicia his ce direc	To B	examiner?  1 V Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nu	ırsing Home 5 🔲 i	Residence 6 Othe	r:
of of g Ph		27 Manner of Death 28a Date of Injury 28h Time of Injury	y 28c. Injury at Work?	28d. Describe h	now injury occurred	
on ath. rr: A	ţį	1 V Natural 5 Pending	1 Yes 2 No			
iSi r Atte recte recte	lica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa	actory, office building, etc.			ural Route Number, City
Division of Vital Records, P.O. Box 68760, as a Attending Physician: The law requires that the death certificate be as fler edeath.  The law Director: After this certificate has been signed by the attending physical led in by the funeral director, page 2 should be detached for use as the buri	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Si	tate)	
lospi 4 hou 'uner	Ö	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place,	and due to the cause	e(s) and manner as sta	ted.
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	one) (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation,	in my opinion, death occurr	ed at the time, date a	and place, and due to the	ne cause(s)
To with To Cour	¥e	and manner stated.    29b. Signature and title of certifier.	29c. License number		29d. Date signed (Mo	onth, Day, Year)
	-	- ( ) - ( )	O.C.M.E.		August 23, 2010	)
		20 Name and address of passes the appearance of the William 22a)				
10		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 21	201		ļ
10		A 100 S : 1 100 S				
S	tate	SEP 0 2 2010				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ August 1<sup>D</sup>7<sup>y</sup>, 2010 3:25 Russell John Neuner Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital Age (In yrs. last birthday) 8. Date of Birth OCT 1936 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F 73 168-28-9572 Pennsylvania Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗌 Yes 2 💢 No Montgomery Village Maryland Montgomery 10e, Street and Number 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be ronce. Funeral 20886 United States 19349 Frenchton Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give 5-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Electrical Engineer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alberta Klinkner John Thomas Neuner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19349 Frenchton Place Montgomery Village, MD 20886 Marlene P. Neuner (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crem 20a. Method of Disposition 20c. Location - City or Town, State Date August 17, 1 Burial 2 X Cremation 3 Removal from State Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final Respiratory enysician/ disease or condition Medical resulting in death) Due to (r as a consequence of Examiner neumonia Sequentially list conditions, Examine Due to for as a consumence of cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Day 5 Other (specify) Pregnant at time of death signed by the at d be detached fo 4 ☐ Pregnant
9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsy performed? Yes 2 No has Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2. No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1- Natural 5  $\square$  Pending 24 hours after death. e Funeral Director; Aft bleted filled in by the fur ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifle 29c. License number 65132 August 17, 2010 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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AUG 2 0 2010

31. Date filed (Month, Day, Year)

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8/11/100

USSE

Medical

\$2. Registrar's Signature

- 9901

Center Drive, Rockville, Md. 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 8:45 p M Mary Ann Palmer Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign **Funeral** ashington, DC 1 M 2 F Hours Sept. Director 86 579-24-0475 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director Wheaton 1 Yes 2 I No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 Funeral 4011 Randolph Road United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: "natural" 3 ™ Widowed 4 □ Divorced White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker the traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file.
Department of Health and Mental h.
Important: If item 27 is marked any injury or other. 17. Father's Name (First, Middle, Last) ၉ Mary "Unobtainable" William O'Brien 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12649 Castile Ct., Woodbridge, VA 22192 Devereux D. Palmer/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/23/10 Silver Spring, MD Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ Cardiomyopathy disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Pneumonia Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for selection requestor of Exami physician and the burial-transit that initiated events or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f q | Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? 24 hours after death. Funeral Director: After this certificate 1 ☐ Yes 2 😿 No 1 Yes 27 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🔀 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital 1 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi

Registrar DHMH 17 Rev 7/2009

State

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only one) 29b. Signature and title of cer

30. Name and address of person who completed

Yeheyis Negussie M.D.

31. Date filed (Month, Day, Year)

AUG

ause of death (Item 23a) (Type, Print)

29c. License number

1500 Forest Glen Rd. Silver Spring, MD 20910

D45471

29d. Date signed (Month, Day, Year)

8/17/2010

10-05952 Brooke Bethany H	lad	Please Ty	pe or Print in tate of Maryla	Black	Indelib partme	ole Ink. Ensu	re All Cop nd Mental	ies Are Leg Hygiene		27694
,	1 F	- For State Registrar				te of Death		Re	g. No.	
Physiciar Medical Examin	***	<ol> <li>Decedent's Name (First, Midd Brooke Bethan</li> </ol>						2. Date of Deatl Month August 8, 2	Day Year 2010	3. Time of Death 0644 hrs
j		4a. Facility Name (if not instituti Howard County Gene		nber)		4b. City, Town, o	r Location of De	ath	4c. County of Death Howard	1
Funeral Director		5. Social Security Number 216–98–0654	6. Sex	7. Age (In yr 29 y r		day) If Under 1 Ye  Months Da		12/7/1 12/7/1	h(MM/DD/YYYY) 9. Bir Foreig Co	
ow any	Ī	Usual Residence of Decedent  10a. State 10b. County  Md Howa:		10c. C	City, Town or Elkri		_			10d. Inside City Limits 1 Yes 2 No
ne Maryland or 28a-f sh	Director	10e. Street and Number 7121 Apt. E Bo		ve		10f. Zip Code 21075		10	g. Citizen of What Cou USA	Intry?
	L	11. Marital Status 1 Never Married 2 N	12. Was Deca Armed Fo	edent Ever in rces?	-	13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Pue		White, etc.	ican Indian, Black,
hours after "natural", Examiner	<u>a</u>	3 Widowed 4 Di 15. Decedent's Education (Sp Elementary/Secondary (0-12		e completed	1) 16a. Do	1 Yes 2 N ecedent's Usual Occup uring most of working lif	ation (Give kind		Specify: Whi	
036 ithin 72 ne.	Completed	Elementary/desortatiny (0-12	2Yrs.	, , ,	Ins	tructional			School Te	acher
1215-0 be filed w be filed w antal Hygie rirked othe cent, the M	8	17. Father's Name (First, Middle Dennis Haddaw	ay		12.00		Joanne			
MD 27 2 should th and Me 27 is ma umatic e	٩	19a. Informant's Name/Relation Jonathan C. Pa		nd)					ber, City or Town, State idge, Md. 21	075.
NOTE, land ages I and It of Heal			on 3 Removal fro	m State	cremator	Disposition (Name of c y or other place) unty Crema	· · · · · ·	Date 3/14/2010	Sykesville	
Baltin Permit. Pa		Donation 5 Other S 21. Signature of Funeral Service			111 00				eral Home & Md. 21784.	
Physician	+	23a. Part I. Enter the disease, of failure. List only one caus		used the de	eath. Do not	enter the mode of dying	g, such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
M. di. al Examiner	Ì	Immediate Cause (Final diseas or condition resulting in death)	e a. <b>Seizur</b> Due to (or as a							Death
	틸	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	consequenc	ce of):					
ecuted and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last	C.	consequenc	ce of):					
	edical	X UNPENDED				er me g908	10-15-1	0 vt		
1 o. at at 6	sician/	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 ✓ Ui	4 Pregna	irth ant at time o	2 [	Fetal death 3 Other (Specify)	Ectopic pre-	gnancy	23d. Date of deliver	y Day Year
P.O. Besthat the designed by the detached is	≥L	Part II. Other significant cond	J J J J J J J J J J J J J J J J J J J		ot resulting	in the underlying cause	given in Part I.		bacco use contribute to	
ds, P requires the seen signs outly be d								24a. Was a	an 24b. Were au	utopsy findings available
Recol The law icate has	Completed						-	perfor 1 ✓ Yes 2	med? death?	
ital sician:	8	25. Was case referred to medic examiner?	Hospital:	npatient 2	✓ ER/Out		Other Nu		Residence 6 Othe	r:
	의: 이	1 Yes 2 No  27. Manner of Death  1 Natural 5 Per	28a. Date	<u> </u>		me of Injury 28c. Inj	ury at Work?		now injury occurred	
Division of Vital Records, tat or Attending Physician: The law requints after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be also also as a should be a s	Certification:	2 Accident Inv. 3 Suicide 6 Co	estigation uld not be 28e. Place	of Injury - A	At home, fari	m, street, factory, office		28f. Location (S or Town, St		ural Route Number, City
hou fill		29a. Certifier 1 Certifying I	Physician: To the bes	t of my know	vledge, deat	h occurred at the time,	date and place, a	and due to the cause	e(s) and manner as stat	ed
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Ex 29b. Signature and title of certif	and manner st	of examination	on and/or inv		on, death occurre	ed at the time, date a	and place, and due to the 29d. Date signed (Mo	
WJL 3	O.C.M.E. August 9, 2010									
	Ī	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
Sta Registr		31. Date filed (Month, Day, Year)  AUG 13 2010  32. Registrar's Signature  August A. Sarks								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend#'s10f.19a.PerFHPCC8-24-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 18. Physician/ 2010 1:08 РМ Parma Vladimir Dusan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Davidsonville Rutherford Manor 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral October 1 X M 2 - F Months Days Hours Min Czech 579-74-1271 .1924 Republic Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🏝 No Marvland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20745 Funeral 202 Panorama Drive 20744 items 23a USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 'natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Federal Government Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dusan Parma Drahomira Polaskova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is Elîska H. 202 Panorama Dr., Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 To Cremation 3 ☐ Removal from State Kalas Crematory 08/20/2010 injury ( Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of uneral Service Lice George P. Kalas Funeral Home, P.A. any 6160 Oxon Hill Rd., Oxon Hill, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death ed by the detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed Were autopsy findings available 24a Was an autopsy Jas prior to completion of cause of death? certificate 2 🗌 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manyler of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury 5 Pending Natural 1 Yes 2 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

State Registrar cause of death (Item 23a) (Type, Print)

27696

Medical	Physician/
	Medical
<b>Examiner</b>	Examiner

Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me-Ilical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit Division of Vital Records, P.O. Box 68760

Sta Registra DHMH 17 Rev 7/2009

	Registrar	C	ertifica	ate of L	eath)			Reg. No	<u>.</u> 0		L 1000
	1. Decedent's Name (First, Middle, Last)		-					2. Date of Death  Month Day Year			3. Time of Death
n/ :al	WILLIAM	PROCTO	R				AŬĜUS	AUGUST 15 2010 5:19			
	4a. Facility Name (if not institution, give street and number)		4b. C	ity, Town, or	Location	of Death		40	. County		
	PATUXENT RIVER HEALTH & RE	НАВ		LAUREL							ORGE'S
		In yrs. last birthda		der 1 Year	If Under		8. Date of Bir	th			place (State or Foreign
1	214-32-9951   1X M 2 G F   77	Yrs.	Montl	ns Days	Hours	Min.	SEPT.	$15^{(y, Year)}$	1932	MAR	YLAND
	Usual Residence of Decedent										
ō	10a. State 10b. County 1	0c. City, Town or	Location							1	10d. Inside City Limits
ect	MD PRINCE GEORGE'S	CHEVER	2T.Y								1 🛚 Yes 2 🗆 No
٥	10e. Street and Number	OHE VE	10f. Zip Code						10g. Citizen of What Country?		
ral	6419 LANDOVER ROAD		2	0785				USA			
nue	11. Marital Status 12. Was Decedent Eve	erin IIS 1			spanic Or	igin? (Spe	cify Yes or No-			a - Americ	can Indian,
γF	1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No		If Yes, s	pecify Cuba	n, Mexica	n, Puerto	Rican, etc.)			k, White,	
q p	3 Widowed 4 Divorced Year or Dates.	MINIT	1 ☐ Yes 2 🛣No Specify:						Specify:	BLA	CK
ete	15. Decedent's Education	16a Dec	redent's I	Isual Occup	ation			16h k	(ind of D	siness In	duetry
ldu	(Specify only highest grade completed)	(Gi	Decedent's Usual Occupation     (Give kind of work done during most of working life. DO NOT use retired)     DIETICIAN						VIIIO OI BU	12111622 1111	dustry
Completed by Funeral Director	Elementary/Seconday (0-12) College (1-4 or 5+) 1 2TH								RIVAT	TE.	
as i	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Mid								
힏	RICHARD EARL PROCTOR		MARY BLANCH							,	
	19a. Informant's Name/Relationship (Type, Print)					4-4- 7in /	2- 4-1				
	SHIRLEY PROCTOR/WIFE						I Route Numbe EVERLY ,				
	20a. Method of Disposition	20b. Place of Dis			- 1		Date				own, State
	1 X Burial 2 Cremation 3 Removal from State	cemetery, c	rematory o	or other plac							
	4 Donation 5 Other (Specify)	MD VETH				8/27	/10				MARYLAND L HOME
	21. Signature of Funeral Service Licensee			and Addres		1					
	R						LANDOV		MARY	LAND	
	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.			-	_	1	A -	-			Approximate Interval Between
	Immediate Cause (Final disease or condition	9 Rtat	is (	Stal	l R	Sla	lder	Car	Les		Onset and Death
	resulting in death)  Due to (or as a continuous and			,			-				
	Cognostially list conditions										
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):									
n/Medical Examiner	Cause (Disease or linjury										
ŵ	resulting in death) Last Due to (or as a c	consequence of):									
dica	d										
Mec	IF FEMALE:										
	23b. Was decedent pregnant 23c. If yes, outcome of	pregnancy	R □ Ector	oic pregnanc	3/				23d. Da	te of deliv	ery
ici	1 Ves 2 No. 4 Pregnant at ti		5 Other		.,				Мо	nth	Day Year
Completed by Physicia	g ☐ Unknown g ☐ Unknown										
γP	Part II. Other significant conditions contributing to death but	not resulting in th	e underlyii	ng cause giv	en in Part	1.	23e. Did t	obacco	use contr	ibute to tl	he cause of death?
be le	MTN						1 🗆	Yes 2	□ No	3 🗆 Pro	bably 4 Unknown
let							24a. Was	an	24b. \	Vere auto	psy findings available
ш								ormed?		death?	mpletion of cause of
ပိ	25. Was case referred to medical					11. (011		2 <b>x</b> N	lo 1	☐ Yes	2 kg No
Be	examiner?			Oth	ace of Dea	,					
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ate	1 Natural 5 ☐ Pending (Month, Day, 1		4	work			28a. Describe i	now inju	ry occurre	au	
titic	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	At home form	M street fee		Yes 2L		006 1	D44	1 \$ 1	n nu Dissa	I Planta Mumbar
Cer	4 Homicide determined 28e. Place of Injury building, etc. (		street, rac	tory, office			City or Tov			er or Hura	l Route Number,
sal (	29a. Certifier 1 X Certifying Physician: To the best of m	v knowledge de	th assiss	Lat the dire	data - · ·	nlace -	d duc to the	nuco(c) -	nd mess	ar an otat	
Medical Certificate:	(Check 2 Medical Examiner: On the basis of examiner	mination and/or inv	estigation,	in my opinio	n, death o	ccurred at	the time, date	and place	e, and due	to the ca	use(s) and manner stated
Σ	only one) 3 L Certifying Nurse Practioner: To the be	st of my knowledg		curred at the 29c. License		e and plac	e, and due to the				tated. Day, Year)
	Lita Dhewiten, N	di			506:	202	(1)		_		
				الا	000	J) ;	7	AU	GUST	16,	2010
	30. Name and address of person who completed cause of dea	(Type, Print) ET DRIVE ELLICOTT CITY, MARYLAND 21042									
	· · · · · · · · · · · · · · · · · · ·			LLLL	COTT	CITY	, MAKYI	TAND	210	+ ∠	
e ar	AUG 1 9 2010 Leven 1	Signature	1								
_		Signature Full									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27697 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death August Physician/ Pfeiffer 2010 8:40 Claire A M Anita Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Julia Manor Healthcare Hagerstown 8. Date of Birth May 26, 1926 Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. g. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 Massachusetts 84 Director 016-20-5139 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No Falling Waters WV Berkeley 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö "natural", or items 23a or Funeral 25419 U.S.A. 278 Merrimack Dr. permit. Page 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 😾 No Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White If Yes, Give Specify: Completed 3 Widowed 4 XDivorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Kitchen Staff Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Dion Lillian Brault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Vance/Daughter 278 Merrimack Dr., Falling Waters, WV Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 Durial 2 X Cremation 3 Removal from State Smithsburg Crematory 8/27/2010 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel . Signature of Funeral Service Licensee J. Me 21742 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, Due to (or as a consequence disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury upertension use as the burial-tran that initiated events Due to or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ò Month Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown 1 ☐ Yes ∠ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 ☒ No မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural injury 1 Yes Investigation s after death Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

A. Naden-Bluch

DIG

the within To the

333 Mill Street, Hoberstown, MD 21740

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Ma	aryland / Depa <i>Cen</i>	rtment of F tificate of D	lealth and N Death		ene 201	0 27698
	Physicia	in/	1. Decedent's Name (First, Middle, Last)	Dipor			2. Date of Death		3. Time of Death
	Medic Examin		Norma Faye  4a. Facility Name (if not institution, give street and number)	Piper	**	Location of Death		4c. County of I	Death
a grander a	Funeral			e (In yrs. last birthday)	If Under 1 Year	erland  If Under 24 Hrs.	8. Date of Birth	Alleg	Birthplace (State or Foreign
	Director		195-42-0803	61 Yrs.	Months Days	Hours Min.	Jun 7,	1949	Country) MD
	yland -f show ed at	ctor	10a. State 10b. County MD Allegany	10c. City, Town or Loc	ation mberland				10d. Inside City Limits
	the Mar or 28a e notifi	Funeral Director	10e. Street and Number		10f. Zip Code		10	ng. Citizen of Wha	1 □ <b>X</b> Yes 2 □ No t Country?
	th with ms 23a must b	ınera	11804 Iowa Drive, N.W.	iver in II S 12 M	Ing Donadent of Ui	21502 spanic Origin? (Spe	acify Van ar No		SA
036	s after des al", or ite Examiner	þ	1  Never Married 2  Married	, If	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		American Indian, Vhite, etc. <b>White</b>
- - - -	72 hour n "natur ledical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k		ation uring most of work	ing	l 6b. Kind of Busin	
212	l within ' /giene. ner thar t, the N		Elementary/Seconday (0-12) College (1-4 or 5	+) Cast	NOT use retired)			WalMa	rt Dept Store
land	l be filec fental H rked ot tic even	To Be	17. Father's Name (First, Middle, Last) Charles Schilling				e (First, Middle, Ma el (Pensy	•	g
Maryland 21215-0036	12 should lith and N 27 is ma r traumat		19a. Informant's Name/Relationship (Type, Print) Richard Piper Hu	sband 11	g Address (Street a	nd Number or Rura Drive, N.	Number, C W. Cun	Dity or Town, State	MD 21502
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Restlawn N	ition (Name of atory or other place <b>Nemorial G</b> a	ardens	Date 2	20c. Location - Cit	
Balti	permit. F Departm Importa any inju	1 8	21. Signature of Funeral Service Licensee	22.		: eni Funeral H irginia Avenu		and MD 215	02
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not enter					Approximate Interval Between
<b>-</b>	nysician/ Medical	8 5	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a	Consequence of):	YIA				Onset and Death Fore DAYS
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<b>.</b>	cate be executed physician and sthe burial-transit	edical E	resulting in death) Last Due to (or as a	consequence of):					
09/89	runcate ling phy e as the		IF FEMALE:	of pregnancy.					
POX	In the Hospital or Atter aing Prysician; The law requires that the death certific after the releash.  To the Funeral Director After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	2 🗌 Fetal death 3 🔲	Ectopic pregnance Other (specify)	у		23d. Date o Month	f delivery Day Year
т. Э. :	es mat traisigned by	l by Pr	Part II. Other significant conditions contributing to death by		derlying cause giv	en in Part I.			e to the cause of death?
Vital Records,	w requir s been s s should	pletec	CITHONIC OBSTANCTIVE PU		ISCHSE	SEVENE	24a. Was an	24b. Were	e autopsy findings available to completion of cause of
Hed H	it The la icate ha r, page 2		DIARCTES 25. Was case referred to medical				autopsy perform 1 X Yes 2	ed? deat	
VITA	ysiciar lis certif directo	To Be	examiner?	ent 2 ER/Outpatient	T +	ce of Death (Checi r: 4 \square Nursing Ho	k o <i>nly</i> one) ome 5 $\square$ Resider	nce 6 ☐ Other (S	pecify)
on or	alh. r After the funeral	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	y 28b. Time of	28c. Injury work	at ? Yes 2 □ No	28d. Describe hov	v injury occurred	
DIMISION	raior Affersa er de al Directo ed in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stree . (Specify)	et, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
:	ie Hospi 124 hou ie Funer oleted fill	Medical	29a. Certifler (Check (Check only one) 3 Certifying Physician: To the best of a 2 Medical Examiner: On the basis of examiner on the basis of examiner on the basis of examiner of the basis of examiner of the basis of examiner.	amination and/or investi-	gation, in my opinio	n, death occurred a	t the time, date and	place, and due to	the cause(s) and manner stated.
	Vithi Conf		29b. Signature and title of certifie	wo	29c, License		29	d. Date signed (M	onth. Dav. Year)
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Pr	int)	14 CAVI	ALE, MAN	ITCAND 2	1502
þ	Stat Registra		JMM-S /2 - MOCW, MD // 31. Date filed (Month, Day, Year) SEP 0 2 2010 32. Registr	r's Signature	bores				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	artment of Heal			iene 010	27699				
		,	1. Decedent's Name (First, Middle, Last)			2. Date of Deat	h	3. Time of Death				
	Physicia Medio		Lorraine Ann Rhodes			August	17, 2010 Year	1:04 P M				
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loca			4c. County of Dea					
المصورا	(		22417 Sweetleaf Lane	Gaithers		[a] a	Montgom					
	Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthday</i> ) 095–38–7972 1 M 2 XF 58 Yrs.	Months Days Hou	Inder 24 Hrs. Jurs Min.	8. Date of Birth Month Day, 04/06/		rthplace (State or Foreign ountry) <b>ew</b> York				
			Usual Residence of Decedent			047007	1752   N	ew TOTK				
	land shov d at	tor	10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits				
	Mary 28a-f otifie	irec	Maryland Montgomery Gait	hersburg				1 Yes 2 XNo				
	h the kaor ben	al D	10e. Street and Number	10f. Zip Code		1	10g. Citizen of What C					
	th wit ms 23	Funeral Director	22417 Sweetleaf Lane	20882			United St					
	r dear		11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 \( \) Never Married \( 2 \) Married \( \) Married \( 1 \) Yes \( 2 \) No	Was Decedent of Hispanie If Yes, specify Cuban, Me	ic Origin? (Spe exican, Puerto i	cify Yes or <b>N</b> o- Rican, etc.)	14. Race - Ame Black, Whit					
99	s after al", o Exam	q p	1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 🖼 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🖾 No Spe	ecify:		Specify: W	hite				
ğ	hours natur lical	Completed by	15. Decedent's Education 16a. Dece	edent's Usual Occupation			16b. Kind of Business	Industry				
2	in 72 e. nan "	шć	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	kind of work done during OO NOT use retired)	most of worki	ng	-					
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n	e filec Ital H ed ot	To Be	17. Father's Name (First, Middle, Last)			e (First, Middle, N						
3	uld by d Mer narke	_	Vladimir Joseph Reznicek				lla Krtil					
Ma	2 sho th and ?7 is r traun			ing Address (Street and No. 7 Sweetleaf			•					
فر	and Healt tem 2		20a. Method of Disposition 20b. Place of Disp				20c. Location - City o					
<u>o</u>	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Durial 2 X Cremation 3 Removal from State cemetery, cre	matory or other place) tan Cremator	1		•	a, Virginia				
Baltimore, Maryland 21215-0036	artme bortar injur							u, viiginia				
ä	Dep Imp		21. Signature of Funeral Service icensee  22. Name and Address of Facility DeVol Funeral Home  10 East Deer Park Drive Gaithersburg,									
Г			23 . Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List only one cause or each line.  Approximate Interval Between									
14	Physician/		Interest to se (Final disease of the second									
	Medical Examiner		Due to (or as a consequence of):									
	Examiner	J.	Sequentially list conditions, Hypertension									
	₩ #	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying	-								
	and and	Exar	Cause (Disease or lifting) that initiated events resulting in death) Last Due to (or as a consequence of):									
_	death certificate be executed he attending physician and ed for use as the burial-transit	dical Examiner										
9/9		<b>l</b> edi										
9	certii anding use a	an/N	F FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1	Ectopic pregnancy			23d. Date of de	livery				
ROX	death	sicia	1 Ves 2 No 4 Pregnant at time of death 5	Other (specify)			Month	Day Year				
д О	requires that the death certifica been signed by the attending p should be detached for use as t	Physician/Me	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	undaylin - anga -ban ba	Dont	T	tobacco use contribute to the cause of death?					
	requires that the been signed by the should be detach	by	COPD, Peripheral Vascular Disease,	underlying cause given in	raici.			Probably 4 X Unknown				
S	equir	Completed										
ပ္က	has by ge 2 s	mpl	Hypercholesterol, Protein C Deficie	псу		24a. Was ar autops	y prior to	topsy findings available completion of cause of				
ř	The ficate r, pag		Seizures 25. Was case referred to medical				ned? death? 2 X No 1 ☐ Ye	s 2 XNo				
Ita	siciar certii irecto	o Be	examiner?  1 \( \overline{\text{X}} \) Yes 2 \( \overline{\text{No}} \) No  Hospital:  1 \( \overline{\text{Inpatient 2}} \) ER/Outpatie	Other:	Death (Check		a 🗆 au - m					
Division of Vital Records,	y Phy er this eral d	e: To	27. Manner of Death 28a. Date of injury 28b. Time of	f 28c, Injury at			nce 6 Other (Spec w injury occurred	cify)				
Ę.	nding ath. r. Afte ie fun	icat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ AccidentInvestigation	work? M 1 ☐ Yes	2 🗆 No							
ISI(	r Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or Ru	ıral Route Number,				
á	ital o Ins aff ral Di Iled in											
	Hosp 24 hou Fune sted fil	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investigation.	stigation, in my opinion, dea	ath occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.				
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director After this certificate has completed filled in by the funeral director, page 2	Ž	only one) 3 L Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, 29c. License numb			cause(s) and manner as 9d. Date signed (Mont					
	F 5 F		1 = 2 OO MAN	D006146			August 18,					
			30. Name and address of person who completed cause of death (Item 23a) (Type,					20886				
			Kathleen Frekko Farrell M.D. 19211	Montgomery V	Village	Ave. Me	ontgomery					
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	المما								
	Registra	ir	AUG 2 0 2010 Senson B. Apar	_								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Physician/ 08718/2018 ANCHETA L. RAMOS 2300 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth g, Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours 04/17/1942 Phillipines Director 590-61-4850 68 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 🗆 Yes 2 🔀 No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 18502 Boysenberry Drive, #157 20879 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 5 þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced Asian item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Baltimore, Maryland 21215-16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the In Factory Worker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adriano Landingin Arcadia Esquerra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 Rodolfo Ramos - husband 18502 Boysenberry Drive, #157, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buyria 2 Cremation 3 Removal from State Souls Cemetery ation 5 Other (Specify) 8/21/10 Germantown, MD Signature of Funeral Service Lice see 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St. Rockville, MD 20850 . Part 1. Enter the dise se, or co shock, or heart failus. List only not enter the mode of dying, such as cardiac or respiratory arrest. ations that caused the death se or comi Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) espiratoru Medical or as a consequence of): Examiner Preumonra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Rena Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Vear 5 Other (specify) Pregnant at time of death g Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signification 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 2 🗌 No 2 🔽 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, upleted filled in by determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d Date signed (Month, Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901

Registrar's Signature

Zhang

AUG 20

31. Date filed (Month, Day, Year)

2010

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		_	For State Registrar	State Registrar  Certificate of Death Reg. No.						201	U	2110	1						
	Physicia Medic		Malar L						Year	3. Time of Deat	th M								
	Examin		4a. Facility Name (if Joseph R		•		mber)			4b. Cit	y, Town, o altin		of Death		4	c. County	of Death		
	Funeral Director		5. Social Security No. 219-70-57	umber 52	6. Sex	M 2 <b>X</b> □ F	7. Age	e (In yrs. Ia 3	ast birthday, Yrs.	) If Unc	der 1 Year s Days	If Unde Hours	Min.	8. Date of Bi (Month, D Jan 2		57	9. Birth Cour	place (State or For	eign
		1 h	Usual Residence of 10a. State	Decedent 10b. County				10c. City	, Town or L	ocation				<u> </u>		,,L		10d. Inside City Lin	nits
	Marylar 28a-f sl otified	irecto	MD					_	anton									1 <b>X</b> Yes 2 □	
	with the s 23a or ust be n	Funeral D	10e. Street and Nun 715 S. D		Stree	et					Zip Code 21224				10g. C	Citizen of W USA	hat Cou	ntry?	
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed			. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	orces? 2 X ive		3. 13		edent of H ecify Cuba 2 🛣 No			cify Yes or No Rican, etc.)	ia.		k, White,		
Baltimore, Maryland 21215-0036	ithin 72 hour ene. <b>r than "natu</b> <b>the Medi</b> cal	Completed	(Spe	15. Deceden ecify only higher onday (0-12)	t's Educa st grade	ation completed College (	<del></del>	+)	(Giv	e kind of w DO NOT u	sual Occup york done o rse retired) Mana	during mo	st of workin	ng	1	Kind of Bu		dustry	
/land 2	d be filed w Mental Hygi arked othe	l as l	17. Father's Name (I		,	ng						18. Mot		(First, Middle					
, Mary	nd 2 should salth and N n 27 is ma er trauma		19a. Informant's Na Mr. Marc	Rossko	ip (Type, pf <del>-(</del>	(Spoo	se)	<del></del>					3	Route Numb			ate, Zip	Code)	
imore	Page nent c ant: If ary or		20a. Method of Disp 1 🛣 Burial 2 l 4 🗌 Donation	☐ Cremation		moval fron	n State	20b. P 010	lace of Disp emetery, cri l Holly	oosition (Nematory or Family	ame of r other plac ily C	em.	8-14	-10		Location - dalls	-		
Balt	permit. Departr Imports any inji		21. Signature of Fur	neral Service L		Her	be	t						ght Fur ille, l			ie &	Chape1	7
	Physician/	00 0	Immediate Cause ( disease or condition	rt failure. List o Final	complica	ations that ause on e	caused ach line	the death		nter the mo	ode of dyin		s cardiac or					Approximate Interval Between Onset and Death	
1	Medical Examiner		resulting in death)	l)	<b>f</b>	Due to	(or a	consequ	ience of):										
200	e executed sian and urial-transit	Examiner	Sequentially list contains, leading to include cause. Enter Under Cause (Disease or that initiated events	rlying linjury	D. о	Dus to	(Ur as a	t Sunsequ	leti <b>c</b> e dij.										
200	e ris		resulting in death) l	Last	d.	Due to	(or as a	a consequ	ence of):								1		
8/16/10 3.0. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	· ·	IF FEMALE: 23b. Was decedent in the past 12 r 1  Yes 2 7	months?	23c		e Birth gnant af		I death 3	☐ Ectopi	c pregnand (specify)	су				23d. Date Mon		rery Day Year	
	uires that the signed by	by	23e. Did tobacco use continuiting to death out not resulting in the underlying cause given in rair i.								he cause of death?								
Kop ? Records,	The law req ate has bee page 2 shor	Completed			_									24a. Was auto peri 1 \( \subseteq Yes	opsy formed?	p	rior to co eath?	psy findings availa empletion of cause 2  No	ble of
Vital	sician: certific rector, I	Be	25. Was case referre examiner?  1  Yes 2	ed to medical	Hos	pital:		- [-]			Oth		ath <i>(Check</i>	only one)				Harris	
J 5	ding Phys th. : After this s funeral di	cate: To	27. Manner of Death  1 1 Natural  2 Accident			28a. Date		y I	ER/Outpati 28b. Time injury		28c. Injur work	y at	2	ne 5 Res				o Holpite	
Division	or Atter after dea Director d in by the	Certificate:	3 Suicide 4 Homicide	6 Could r determi	not be	28e. Place build	e of Inju ling, etc	ry - At ho :. (Specify	me, farm, s	treet, facto	ory, office		2	28f. Location City or To			r or Rura	l Route Number,	
<u></u>	n Hospital or 24 hours afte Funeral Dire Funeral Dire bleted filled in I	Medical	(Check 2	Certifying  Medical E	xaminer:	On the ba	asis of ex	xamination	and/or inve	estigation, i	in my opinie	on, death o	occurred at	the time, date	and place	ce, and due	to the ca	iuse(s) and manner :	stated.
_		_	29b. Signature and		.0						9c. Licens	e number				ate signed	(Month,		
	WIL		30. Name and addre	ess of person v	yho com	pleted cau	ise of de	eath (Item	23a) (Type	Print)	HO	0642	167			8-1	1-10		
	φ			on ka	een	Cer	<i>sutj</i>	BUR	un	82	7 Lu	nden	A	Butt.	HD.	2120			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robertson 2010 0636 AM Ana 7 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmare umma Cotyof Baltimore. 8. Date of Birth (Month, Day Ye Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Year) 192<u>9</u> 1 M 2 X F Hours Maryland 81 Yrs Director 215-32-9392 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Cecil Port Deposit 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1101 Bainbridge Road 21904 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black White etc. 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes Give 3 M Widowed 4 □ Divorced Specify: Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Citizens Nursing Home Elementary/Seconday (0-12) College (1-4 or 5+) Havre de Grace, Maryland Head Cook Twelve Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Margreta Pitt Alexander Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 207 Ellerslie Court, Abingdon, Maryland 21009 Charmaine P. Robertson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cokesbury Cemetery 1 Durial 2 Cremation 3 Removal from State 08/21/10 Port Deposit, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home. Momasm Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ntracranix disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): laticia Alenia CERTIFICATION APPROVED BY MEDICAL FXAMINE 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e 2 certificate har irector, page 2 performed? 2 🗌 No Yes 2 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: ုင 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending work? 1 ☐ Yes 2 Ø No nours after death.

neral Director: Aff Ang 16,2010 fall 3100 LW 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) P.O. BOX 66 Part apposit home 24 hours a Funeral L Hospital Medical 🖂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completed fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier - mays 16,2010 0333892

State Registrar umme

31. Date filed (Month, Day, Year)

Balton

MO 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

Greche

St.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Robert W. Russell 8 2010 25 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 5129 Rondel Place Columbia Howard Sex 14 M 2 D F 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Hours Min (Month, Day, Year 1/5/1944 141-34-8026 66 N.T Lisual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5129 Rondel Place 21044 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

14 Yes 2 No Black White etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes Give Specify. 3 - Widowed 4 - Divorced Year or Dates. 1966-72 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Industry Publisher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert C. Russell Rose Molino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5129 Rondel Place Columbia, MD 21044 <u> Barbara Russell - Wife</u> 20a. Method of Disposition
1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Ardent Cremation 4 ☐ Donation 5 ☐ Other (Specify) 8/20/2010 Hanover, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc M00845 4112 Old Columbia Pike Ellicott City, MD 21043 lando 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Due to (o as a consiquence of): cancer disease or condition resulting in death) 4 months Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month 4 Pregnant at time of death 9 Unknown 5 Other (specify) Day Year 1 Yes 2 9 Unknown

Physician/ Medical Examiner

attending physician and for use as the burial-transit

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After

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To the Funeral Director: A

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funeral director,

by Physician/Medical

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Certificate:

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

Completed by

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Examiner

Funeral

Director

death with the Maryland

be filed within 72 hours after

Baltimore, Maryland 21215-0036

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at

and Mental Hygiene. Is marked other than

permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No 3 Probably 4 Unknown 24a. Was an

autopsy performed Yes 2 26. Place of Death (Check only one)

b.		psy findings available	
	prior to co	impletion of cause of	
	death?	1.	
	1 Tes	2 No	

25. Was case referred to medica examiner? 1 🗌 Yes Manner of Death

28a. Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be

determined

28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of iniury Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number.

24

23e. Did tobacco use contribute to the cause of death?

29a. Certifier (Check only one

Rosalyn

31. Date filed (Month,

1 Natural

Accident

29b. Signature and title of certifie

Homicide

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

eus mo ses of person who completed cause of death (Item 23a) (Type, Print) D 60203

29c. License number

2010

29d. Date signed (Month. Day, Year)

124 State

Registrar

401 North Broadway Johns Hopkins Juergers, wo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ August 23 25 Elva Runkle 2010 4:45 A M Parks Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Somerford Assisted Living Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 X October 28, 1915 180-01-9721 94 Director Yrs Pennsylvania Usual Residence of Decedent Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". with any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States of America 21702 2100 Whittier Drive 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc ğ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Credit Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Mary Hall Ira J. Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Carroll Parkway, Apartment 209, Frederick, Maryland 21701 Sally Gartner / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 28 1 x Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) **2010** Keeney & Basiord F.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final Approximate Interval Betweer Onset and Death Physician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last physician a the burial-t Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Assisted 6 Other (Specify) Living Hospital: Other: No. 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Director: 3 Suicide within 24 hours after de:

To the Funeral Director

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, dea occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Robert Kaufmann, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

300 West Ninth Street, Frederick, Maryland 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Dep State Registrament#10e+19bperFH,8/25/10,BM@a		Mental Hygier Reg.	2010	27705
Ph	nysicia		1. Decedent's Name (First, Middle, Last)  Lynn S. Shin		2. Date of Death A North . 18,		3. Time of Death 2:10p M
_ E	Medic xamin		4a. Facility Name (if not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Sprin		4c. County of Deat	
	ineral rector		5. Social Security Number $\begin{bmatrix} 6. \text{ Sex} \\ 1 \ \square \text{ M} \end{bmatrix}$ Age (in yrs. last birthday, $\begin{bmatrix} 7. \text{ Age (in yrs. last birthday,} \\ 52 \ \text{Yrs.} \end{bmatrix}$	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 3 / 20 / 195	9. Bird 0.8 S	hplace (State or Foreign untry) Korea
Maryland	Aaryland Ba-f show tified at	l. 1	Usual Residence of Decedent  10a. State	ocation ge Park			10d. Inside City Limits 1 Yes 2 No
with the P	s 23a or 2 ust be no	Funeral Director	10e. Street and NumbNiagara 4814 <del>Niagra</del> Road	10f. Zip Code 20740	10g.	Citizen of What Co USA	untry?
)036 urs after death	ural", or item: I Examiner m	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates.	Was Decedent of Hispanic Origin? (Spulf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: A:	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene.	er than "nat the Medica	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) ashier	ing 16b	. Kind of Business Delica	
/land d be filed v Aental Hyg	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Chang Mon Mun	Yeon	e (First, Middle, Maide Soon Mun		
Mary d 2 should salth and N			19a. Informant's Name/Relationship (Type, Print) Steve S.Shin/Husband  19b. Mai 48	ling Address (Street and Number or Rura 14 <del>Niagra</del> Road	al Route Number, City College	or Town, State, Zip Park , Md	. 20740
Page 1 an			4 🗆 Donation 5 🗀 Other (Specify)	i Heaven 8/20	/2010 s		pring,Md
Balt permit Depart	any in		21. Signatur / Juneral Service Life see	MadaR∧DesRTNALDI 241 Columbia Bl	FUNERAL vd.Silve	SERVIC r Sprin	E,P.A. g,Md20910
	ician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition and diseas		or respiratory arrest,		Approximate Interval Between Onset and Death MONTHS
	edical miner	<u>.</u>	Bone metaste		months		
per B	nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events		mpnths		
760 icate be exe	g physician and sthe burial-transit	edical Ex	resulting in death) Last  Due to (or as a consequence of):  d.				
Box 68 death certif	/ the attending p	Σ		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	ivery Day Year
Is, P.O	n signed by	2	Part II. Other significant conditions contributing to death but not resulting in the cachexia, terminal delirium	underlying cause given in Part I.			the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the restler death.	sate has bee page 2 shou	Completed			24a. Was an autopsy performed 1 \(\sum \text{Yes}\) 2	prior to death?	topsy findings available completion of cause of
ital sician:	certific rector,	m l	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:   Managing 2 FR/Output	26. Place of Death (Check			-
of V ing Phys	offer this uneral di	ate: To	1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpati  27. Manner of Death 1 ☑ Inpatient 2 ☐ ER/Outpati 28a. Date of injury (Month, Day, Year) injury	of 28c. Injury at work?	ome 5 Residence 28d. Describe how in		ify)
Division all or Attends after death	d in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined lower building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No treet, factory, office	28f. Location (Street City or Town, Sta		ral Route Number,
Le Hospita n 24 hours	ne Funera pleted fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death only one)  3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred a	t the time, date and pla	ace, and due to the	cause(s) and manner stated.
	_	-	29b. Signature and title of certifier	29c. License number		Date signed (Month	
10	)		Barbara Suparich RSM 110	D0045485		08/18/8	2010
				Forest Glen Rd.	Silver	Spring,	Md
R	Stat egistra		31. Date filed (Month, Day, Year)  AUG 2 0 2010  32. Registrar's Signature  August B.	le d			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SHERMAN MICHAEL STUARI 0158 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 12/04/194 Country) Virginia 1 🔀 M 2 🗆 F 62 Director 231-66-5551 Usual Residence of Decedent show 10a. State the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Montgomery North Potomac Page 1 and 2 should be filed within 72 hours after death 74th the ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or? 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral CHE 14020 Welland Terrace 20878 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Association Elementary/Seconday (0-12) College (1-4 or 5+) Research, Inc. Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert Sherman Helen Brenner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adam Sherman, son 14020 Welland Terrace, North Potomac, MD 20878 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Judean Memorial Gdns 08/18/2010 4 ☐ Donation 5 ☐ Other (Specify) Olney, Maryland of Funeral Service Licensee EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 Rockville Pike, Rockville, Maryland MO1255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Esophagea Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate Cause (Disease or linjury that initiated events burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 No Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No 1 Tes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

10

D32407

Medical Center Drive

Rockvill

40seph Michael Has

M. Haga

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.O.

/32. Registrar's Signature

tus

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 17, 2010 Physician/ 8:25 A M June J. Selden Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Spring House Manor Care Silver Spring Montgomery 8. Date of Birth
(Month, Day, Year)
April 30,1922 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X F Washington, DC Director 579-20-7406 88 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 XYes 2 No DC Washington None 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral United States 20012 6661 13th Street, North West 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black "natural", 3 Divorced Completed Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic manner. Elementary/Seconday (0-12) College (1-4 or 5+) Education 4 Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ William Harold Joice Lillian May Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13th Street, N.W. Washington, D.C. 20012 Wendell H. Joice/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State **X**Burial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 □ Other (Specify) 08/20/2010 Laurel, Maryland Maryland National 21. Si ture of Funeral Service License 22. Name and Address of Facility McGuire Funeral Service, Inc. ONL 7400 Georgia Avenue, N.W. Washington, D.C. 20012 23a. Part 1. Enter the disease, or somplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Cardio-Respiratory Failure disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Chronic Hypertensive Heart Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) requires that the death certificate be executed **Emphysema** that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Chronic Kidney Disease - Stage III Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Vear 5 Other (specify) Pregnant at time of death Yes 2 X No ed by the a g Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been signated the could be compared to the could be comp 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performe this certificate 1 ☐ Yes 2**X** No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific.

Completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending work' 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63232 August 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Gomez, 15245 Shady Grove Road, Suite 130 Rockville, Maryland 20850

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 0 2010

32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#19 openFH, 8/23/10, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last)

Darfony
P. 2. Date of Death 3. Time of Death Parfeny Saworotnow Month Physician/ 08 Medical <sup>4a.</sup> Facility Name *(ff not institution, give street and number).*Washington Adventist Hospital Examiner 4c. County of Death Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. 2 7 2 0 7 1 9 2 4 551-42-4837 86 Russia Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Prince George Hyattsville 1 Yes 2 □ No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 20782 USA 6 Avon Place death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Black, White, etc.
White Armed Forces? 1 Never Married 2 Married þ Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) of Math Professor Catholic University and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul I. Saworotnow permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or color. Anna D.Soloview 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 11508 Harvard Drive Norwalk, California 8 90650 19a. Informant's Name/Relationship (Type, Print)
Ivan Saworotnow/Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Rock Creek Cem. 8/20/2010 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) PATE PAD RENALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 21. Signature o Fu ral/s 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Pflysicially disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit Due to (or as a consequence of): resulting in death) Last The law requires that the death certificate be ex Medical Division of Vital Records, P.O. Box 68760 attending pl IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the a Yes 2 No 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 21 No Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 🛂 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending after death. 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 24 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier alD D0063703 Uleis TAKOMA PARK, MD - 200

State Registrar

arked.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

SABYASACH KAR

31. Date filed /Month. Dav. Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 20a, State of Maryland / Department of Health and Mental Hygiene State Registrate 20b WCHD/SH 8/25/10 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 9.25 PM tugust John Senuta 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 5. Social Security Number 7, Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Oct. 1 Min 1 XM 2 🗆 F 184-16-5888 Pennsvlvania Director 88 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland Washington County Maugansville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13906 Green Mountain Dr. 21767 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give 1942 Year or Dates. 1945 1 Never Married 2 X Married 72 hours after Completed by 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than " College (1-4 or 5+) Elementary/Seconday (0-12) Mechinist Truck Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or cet. ဂ John Senuta, Sr. Kathryn Wawryn Senuta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13906 Grenn MountainDr. Maugansville, MD 21767 Ann Senuta-wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Park 8/24/2010

Smithsburg, MD 21783

Hagerstown, Maryland Smithsburg, MD 217/12

Hagerstown, Maryland Smithsburg, MD 217/12 20a. Method of Disposition 1 X Duriel 2 X Cremation 3 Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1331 Eastern BLvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ myocardi disease or condition Medical resulting in death) Due to (or as a consequent e of). Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv death? 1 ☐ Yes 2 ☐ No certificate Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🛛 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ္ဝ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of completed filled in by the funer. injury X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month. Day, Year) ARU 2010

State Registrar

JSH 9+1

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

DHMH 17 Rev 7/2009

30. Name and address of pe

edical Compus Rd.

on who completed cause of death (Item 23a) (Type, Print)

real

Amended Item Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20a per F.D. 08/1//10 Carroll County, will State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 15 2010 Physician/ Margaret A. Swope 2:48 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** 1 □ M 2 😿 F Months Min. Hours oct 11, Year) 946 Pennsylvania 175-36-1447 63 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must he matitud as 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Completed by Funeral Director Finksburg Maryland Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2103 Woodview Road 21048 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pauline E. Kuhn Jacob R. Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Ford, daughter 1427 W. Market Street, York, PA 17404 20a. Method of Disposition 20b. Place of Disposition (Name of Hamer) Place) 20c. Location - City or Town, State Date 1 🗌 Burial 2 🛛 Cremation 3 💢 Removal from State 8/16/2010 Hanover, PA Cremation Services Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Part J Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner equentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year ed by the a 9 Unknown Division of Vital Records, P.O. sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cell lines cance 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No After this certificate 24 hours after death.

Funeral Director: After this certifical leted filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other SHOSPICE 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural (Month, Day, Year) 5  $\square$  Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) npleted filled Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F
complet To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Man Mos a MJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Westminster MD 21157 349 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert O. Stiles 3:35 Рм 2010 Auaust Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Larkin Chase Nursing and Restorative Bowie Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 ☑M 2 ☐ F Hours Min (Month, Day, Your 19 578-36-5045 **Director** 79 March 1931 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Laurel 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ٥ ral", or items 23a or Examiner must be Funeral 9010 Briarcroft Ln., Apt. 221 20708 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1X Never Married 2 ☐ Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: White Completed 3 Divorced 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Landscaper Landscaping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked in jury or other traumatic ew 2 Clifford A. Stiles Lillian M. Squires 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Miller / Sister 7840 C Street, Chesapeake Beach, MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 08/20/2010 | Suitland, Maryland Cedar Hill Cemeterv 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Yneumonis disease or condition resulting in death) 1001 Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine cause. Enter Underlying Due to (or as a consequence of): death certificate be executed bunial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Pregnant at time of death the 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 S Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No ٥ 1 🛣 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Mont)

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person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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18. Mother's Name (First, Middle, Maiden Surname)

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm My dical Evarinar must be notified at once. Baltimore, Maryland 21215-0036

1 - For State Registral

10a State

17. Father's Name (First, Middle, Last)

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Graciano

Funeral Director

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Completed

Be

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12721 Norwood Lane Ft. Washington, Maryland Amelia Laguilles / Sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State St. Mary's Ch. Cem. 08/23/2010 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home PA Hoyl 1 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Doa Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Q the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □ No 1 □Yes 🔭 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11711 Livingston Road Ft. Washington, Maryland Amir Mirza-Alikhani MD31. Date filed (Month, Day, Year) AUG 2 0 2010 32. Registrar's Si mature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

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	Ž	29b. Signature and title of certifier	29c.		se number .M.E.			Date signed (Mo gust 17, 2010		
		30. Name and address of person who completed cause of death (item 23a)		0.0.						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 24 Day 2010 ear 4:50 A. M Virginia Belle Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Julia Manor Healthcare **Hagerstown** 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Year) 1920 Month, Day, Min Hours 1 □ M 2 🔽 F 216-54-7999 90 **Director** Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a, State Director Smithsburg 1 Yes 2 No MA. Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21783 U.S.A 11631 Crystal Falls Dr. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Elmer S. Leather Sr. Sadie G. Pound 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11623 Crystal Falls Dr. Smithsburg, Md. 21783 Susan E. Blake (Daughter) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Aug Date 27 permit. Page 1 a Department of H Important: If ite any injury or ot 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, Md. Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequance of) Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to or as a consequence of) use as the burial-trans Hospital or Attending Physician: The law requires that the death certificate be execute the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month ó Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementio Records, Completed page 2 should 24b. Were autopsy findings available rajor 24a Was an prior to completion of cause of death? autopsy certificate has Cancer DREast 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p 26. Place of Death (Check only one) **Division of Vital** Be 25. Was case referred to medica examiner?
1 Yes 2 No Other: 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Mill Street, Haverstown, MD 21740 bara Naden 0 2 2010 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 SINDY Day 27 2010 Physician/ THOMAS 12:22AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death AHNRC CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** M2□F Months Days Hours (Month, Day, Year) **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director · 28a-f 1 XYes 2 No MD Allegany Cumberland 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 730 Furnace Street 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black. White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: WHITE "natural" Completed 3 Widowed 4 Divorced er than "natur , the Medical | 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Textile Laborer is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pearl Gracie (Snyder) Sindy

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Thompson Sindy 19a, Informant's Name/Relationship (Type, Print) Department of Health Important: If item 27 any injury or other to once. Dolores Sindy wife <u>730 Furnace Street</u> <u>Cumberland</u> MD 21502 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/30/2010 <u> Hillcrest Memorial Park</u>  $\Box$ Cumberland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. P. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) burial- ransi Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month 1 ☐ Yes 2 L 9 ☐ Unknown Yes 2 No Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 - No Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Af 2 Accident
3 Suicide 2  $\square$  No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0054004 Mena 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Shiv Khanna M.D

31. Date filed (Month, Day, Yea **SEP 0 2 2010** 

32. Registr 's Sign

1221 E. National Highway LaVale MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 23 2010 Arline Skiff 5:05 p M Elizabeth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 271 Pinoak Lane Frederick Frederick If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 28, . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗓 F New York 561-52-4560 1937 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c, City, Town or Location 10d, Inside City Limits 10a. State Director Frederick Frederick Maryland 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21701 U.S.A. 271 Pinoak Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify White Completed 3 X Widowed 4 Divorced Year or Dates and Mental Hygiene.
is marked other than "natur raumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) 2 Melvin E1wood Drew Ethel Mae Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 913 Motter Place, Frederick, Maryland 21701 19a. Informant's Name/Relationship (Type, Print) Cathleen Roberson, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9 1 Burial 2 X Cremation 3 Removal from State Resthaven Mem Gardens Aug 28, 2010, Frederick, MD 4 Donation 5 Other (Specify) injury 21. Signat re of Fune al Service Licens 22. Keeney & Bastord P.A. Funeral Home 106 East Church St, Frederick, Maryland M00706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death 2 years Immediate Cause (Final non-small cell lung cancer Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown been si should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has bage 2 s autopsy performe 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify)

the Hospital or Attending Physician: The law requires that the death certificate be executed

Be မ

r this certificate hara After thi funeral ithin 24 hours after death.

the Funeral Director: Ai
ompleted filled in by the fu

Certificate: Medical

27. Manner of Death

1 X Natural

Accident
Suicide

4 Homicide

29a. Certifier

(Check

only one

29b. Signature and title of certifier

within 2. 2 State

30. Name and address of person who comple 501 West Seventh Street, Frederick, Maryland 21701 Elhamy Eskander, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 2 2010

5 Pending

Investigation 6 Could not be

determined

. Date of injury (Month, Day, Year)

Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ted cause of death (Item 23a) (Type, Print)

28c. Injury at

🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

work'

29c. License number

D48184

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

August 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201°0 1:34 P M Tedrick August Eddie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington 351 Key Ave. Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Funeral Age (In vrs. last birthday) (Month, Day, Hours Min Months 1 🕅 M 2 🗆 F Maryland Director 79 215-36-7211 Jan. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗆 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21740 351 Kev Ave. U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. ٥ þ 1 Never Married 2 X Married 1 ☐ Yes 2 🌠 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates White the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " Automotive Elementary/Seconday (0-12) College (1-4 or 5+) Quality Control Specialist Manufacturing 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental F Important: If item 27 is marked o any injury or other traumatic eve William C. Tedrick Rhoda B. Hawbaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Tedrick/Wife 351 Key Ave., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 8/23/2010 Hagerstown, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 Part 1. Enter the disease, or complication of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complicat Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 5 mon ears Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s perform certificate 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 2 X No 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director; After tholeted filled in by the funeral 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending work? 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Tpleted 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complet 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2018 Phillip E. Truesdale August (1-4517 M Medical Truesdale, Phili 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BANTMORE IXLACATINGTON MEDICAL CER BURNIE MNE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 1 M 2 □ F Months Days Hours Dec 29 1948 Marvland 217-52-2938 Director 61 Usual Residence of Decedent 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Anne Arundel Odenton 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 1221 Collins Ave 21113 USA death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates 1968 — 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. Black, White, etc. ō þ 1 Never Married 2X Married hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: "natural" 3 Widowed 4 Divorced Completed **Black** 70 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Department of Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 Print Operator Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry D. Truesdale Grace J. Miller traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Bonita R. Truesdale(Wife) 1221 Collins Ave Odenton, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8-20-10 Maryland Veteran : Crownsville, Md. 21. Signature of Funeral Service Licensee Mame Rease of Scilis Ons Mortuary, P.A. 821 West St. Annapolis, Md. 100463 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease of it that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic preg... 5 Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Month Pregnant at time of death Day Year 9 Unknown Unknown nas been signed by 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. з 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 2D 145149 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie MJ 20161

State

Registrar

Date filed (Month, Day

**482010** 

gistrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>010</u> Physician/ Month VIVIAN DELORES JONES TOLLIVER Рм 1640 August 16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year June 4, 1 M 2 X F Days Min Months Hours 54 Director 579-10-6478 956 Halifax, NC Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC District of Columbia Washington 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 3904 13th Street, NW 20011 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ð 1 Never Married 2 Married hours after ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: "natural" 3 🔀 Widowed 4 □ Divorced Specify: Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Secretary Law Firm and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nathaniel Lewis Tabron Annie Virginia Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Shenika Jones - Daughter 3904 13th Street, NW, Washington, DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Glenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 08-21-2010 Washington, DC 21. Signature Function Service I see 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph sician/ CARDIOPULMONARY ARREST disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner TERMINAL AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year signed by the at the detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsv certificate 2 X No 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🛣 No Other: မှ 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify, this 1 K Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 K Natural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident Suicide

Division of Vital Records, P.O. Box 68760 Hospital 24 hours Funeral

completed within 2 State Registrar

Holy Cross Hospital, 1500 Forest Glen Road, Silver Spring, MD 20910 Sirak Lemma, MD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Medical

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0065069

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

en

28f. Location (Street and Number or Rural Route Number

08-17-2010

29d, Date signed (Month, Day, Year)

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department State of Maryland / Department Contification	nt of Health and Menta e of Death	al Hygiene	27720					
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No. U I U	3. Time of Death					
	Physicia Medic		W. Warren Taltavull	Aug	gust 15° 2010 ear	9:15P м					
	Examin			Town, or Location of Death kville	4c. County of Dea						
~ :	Funeral Director		578-05-3458 1 ★ M 2 □ F 89 Yrs. Months		tte of Birth lo <i>nth, Day</i> Year) 1920 Wa	thplace (State or Foreign untry). Shington, DC					
	nd ihow at	٦Ľ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
	Maryla 28a-f s atified	Director	Maryland Montgomery Silver Spring			1 🗆 Yes 2 No					
	with the s 23a or 3 ust be no	Funeral Di	10e. Street and Number 10f. Zi 3330 N. Leisure World Blvd. #219 20e	o Code 906	10g. Citizen of What Co USA	ountry?					
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If then Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Nover Married 2 Married 4 TV	dent of Hispanic Origin? (Specify Yecify Cuban, Mexican, Puerto Rican, 2 No Specify:							
Baltimore, Maryland 21215-0036	vithin 72 hou giene. er than "natu the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  1 College (1-4 or 5+) 2 Self-emple	rk done during most of working e retired)	16b. Kind of Business Funeral D						
land	d be filed value of the land of the land land land land land land land land	To Be	17. Father's Name (First, Middle, Last) W. Warren Taltavull	18. Mother's Name (First, Ellen Bur	Middle, Maiden Surname) cke						
Mary	d 2 should alth and N 27 is ma er trauma			s (Street and Number or Rural Route George St. Annap		o Code)					
more,	Page 1 an nent of He int: If item iry or othe		20a. Method of Disposition  1	other place)	20c. Location - City or Edgewater,						
Balti	permit. I Departm Importa any inju		21. Signatur, of Funeral Service Licensee 22. Name a	nd Address of Facility George Oxon Hill Rd. Oxo	P. Kalas Funer	al Home					
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.	e of dying, such as cardiac or respir	ratory arrest,	Approximate Interval Between					
F	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)  Congestive Heart Fail	ure		Onset and Death					
	Examiner		Due to (or as a consequence of):								
-	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury								
	ite be executed hysician and the burial-transit	dical Exa	that initiated events resulting in death) Last  Due to (or as a consequence of):								
3760	fficate ig phys as the	Medi	IF FEMALE:								
. Box 687	or Aftending Physician: The law requires that the death certificate be executed after death.  Jarcetor: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1 Live Birth 2 Fetal death 3 Ectopic  4 Pregnant at time of death 5 Other (s.		23d. Date of de Month	livery Day Year					
Division of Vital Records, P.O.	v requires that the dea s been signed by the a should be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying Prostate Cancer	cause given in Part I. 23	Be. Did tobacco use contribute to						
ecord	e law requ s has beer ge 2 shou	Completed by			autopsy prior to performed? death?	topsy findings available completion of cause of					
<u>8</u>	ian: Ih rtificate stor, pa	Be Co	25. Was case referred to medical examiner?	26. Place of Death (Check only or	*	s 2 🗆 No					
<b>Ξ</b>	hysic this ce al direc	ပ္	1  Yes 2 No 1 Inpatient 2 ER/Outpatient 3 D		☐ Residence 6 👿 Other (Spec	Hospice					
o uc	nding l ath. :: After e funer	icate	27. Manner of Death   28a. Date of injury   28b. Time of   28a. Date of injury   28	28d. De work? 1 ☐ Yes 2 ☐ No	escribe how injury occurred						
OIVISIC	al or Atters at after degree of the state of	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)		cation (Street and Number or Ru ty or Town, State)	ral Route Number,					
<b>-</b>	io the hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check (Check only one) 3 X Certifying Physician: To the best of my knowledge, death occured at 2 Medical Examiner: On the basis of examination and/or investigation, in only one) 3 X Certifying Nurse Practioner: To the best of my knowledge, death occured at 2 Medical Examiner: On the best of my knowledge, death occured at 2 Medical Examiner: On the best of my knowledge, death occured at 2 Medical Examiner: On the best of my knowledge, death occured at 2 Medical Examiner: On the best of my knowledge, death occured at 2 Medical Examiner: On the best of my knowledge, death occured at 2 Medical Examiner: On the best of my knowledge, death occured at 2 Medical Examiner: On the best of my knowledge, death occured at 2 Medical Examiner: On the basis of examination and/or investigation, in	my opinion, death occurred at the time	e, date and place, and due to the	cause(s) and manner stated.					
_	vithi To th comp		29b. Signature and title of certifier 29c	c. License number R120698	29d. Date signed (Monti	n, Day, Year)					
			30. Name and address of person who completed cause of death (Item 23a) (Type Print)		8/17/2010						
2	10		Nicole R. Christenson, CRNP 6001 Muncaste	r Mill Rd. Rockv	ille,MD 20855						
	Stat Registra		31. Date filed (Month, Day, Year)  AUG 2 0 2010  32. Registrar's Signatur  33. August								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 | 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AUGUST MARGARET 2010 THOMAS 7:35  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4010 24th Avenue Prince George's Temple Hills Social Security Number 9. Birthplace (State or Foreign Country)
St. Marys Co.MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 F Months Days Hours Min 12/6/1926 Director <u>2</u>13-24-3895 83 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 TyrYes 2 No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4010 24th Ave. 20748 United States should be filed within 72 hours after death w n and Mental Hygiene. 7 is marked other than "natural", or items ? 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No ģ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Food Service DC Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert Crain Thomas other traumatic Margaret Contee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u>Juanita O. Coye Bailey / Daughter</u> 1332 Queen Street NE Washington, DC 20002 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Aemoval from State 4 Donation 5 Other (Specific 8/14/2010 | Suitland, Maryland Washington National 21. Signature of Funeral Service Lio 22. Name and Address of Facility Pope Funeral Homes, P.A. MULOS 538 Marlboro Pike Forestville, Maryland 20747 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) METASTATIC LUNG CANCER UNKNOWN Medical Due to (or as a consequence of) Examiner Gaquernially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month the i ☐ Unknown 9 Unknown cate has been signed by tage 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 □xNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 No 1 Natural injury 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number onthia M. Dilliamo Da Н 0058032 August 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Cynthia M. Williams

32. Regi trar's Si

31. Date filed (Month, Day,

AUG 1 9 2010

3720 Upton Street NW Washington, DC

lease	Type of Print in Black indelible link. Ensure All Copies Are Legibl	e.				
	State of Maryland / Department of Health and Mental Hygiene	2	N	ì	N	2
		( -	U.	- 8	0	-

Gilbert Edward Tho	mas State of Maryland / Depa	artment of Health and Mental Hygiene rtificate of Death	2010 27722 Reg. No.							
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	2. Date of De Month THOMAS —II III August 1	ath 3. Time of Death							
	4a. Facility Name (if not institution, give street and number) 2610 Kent Village Drive	4b. City, Town, or Location of Death  Landover	4c. County of Death Prince George's							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. I: 212–94–6325 1XM 2F 30		irth(MM/DD/YYYY) 9. Birthplace (State or Foreign ANRYLAND							
with the Maryland ns 23a or 28a-f show any be notified at once. eral Director		Town or Location  CARROLLTON  10f. Zip Code	10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country?							
or ite	5512 KAREN ELAINE DRIVE # 606  11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No specify:	White, etc. Specify: BLACK							
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner To Be Completed by 1	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  9TH  17. Father's Name (First, Middle, Last)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)     NONE     18.Mother's Name (First, Middle)	16b. Kind of Business/Industry  NONE  Maiden Surname)							
MD 21215 d 2 should be file lith and Mental H or 7 is marked or numatic event, II	GILBERT EDWARD THOMAS JR.  19a. Informant's Name/Relationship (Type, Print)  MONA LISA JONES/MOTHER	MONA LISA JONI 19b. Mailing Address (Street and Number or Rural Route No. 5512 KAREN ELAINE DRIVE # 60	umber, City or Town, State, Zip Code) 1784 O6 NEW CARROLLTON, MD							
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and In Important: If item 27 is in injury or other traumatte	1 Burial 2 X Cremation 3 Removal from State	Date   Place of Disposition (Name of cemetery, crematory or other place)   VERDALE CREMATORY   8/21/2010	20c. Location - City or Town, State  RIVERDALE, MARYLAND  ENKINS FUNERAL HOME							
Physician	7474 LANDOVER ROAD LANDOVER, MARYLAND  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Applications of pulletary arrest and provided the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart B									
executed an and an transit all transit ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Multiple Gunshot Wound Due to (or as a consequence or condition).  Due to (or as a consequence or condition).  Due to (or as a consequence or condition).									
68760, certificate be nding physici isse as the buri	UNPENDED  AMENDED #1perME  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  AMENDED #1perME  1 Live birth 4 Pregnant at time of de 9 Unknown	2 Fetal death 3 Ectopic pregnancy eath 5 Other (Specify)	23d. Date of delivery  Month Day Year							
P.O. es that the igned by be detach		1 Yu	tobacco use contribute to the cause of death?  es 2 No 3 Probably 4 Unknown  s an popsy prior to completion of cause of death?							
of Vital Records mg Physician: The law requi	25. Was case referred to medical examiner? Hospital: 1 lengticat 2	1 ✓ Yes  26 Place of Death (Check only one)  ER/Outpatient 3 DOA Other4 Nursing Home 5	2 No 1 ✓ Yes 2 No  Residence 6 ✓ Other: Scene							
F F F F F F F F F F F F F F F F F F F	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28b. Time of Injury 28c. Injury at Work? 28d. Describe Subject sh 1 Yes 2 ✓ No ome, farm, street, factory, office building, etc. 28f. Location of Town,	e how injury occurred ot (Street and Number or Rural Route Number, City							
Divisic To the Hospital or Atte within 24 hours after des To the Funeral Directo completely filled in by th	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowled	ge, death occurred at the time, date and place, and due to the cau and/or investigation, in my opinion, death occurred at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)							
•	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year)  August 13, 2010							
State	Russell Alexander MD. Assistant Medical Exam	niner 111 Penn Street, Baltimore, MD 21201								

20b. Place of Disposition (Name of

**Physician** /Medical Dorothy Thompson (wife)

Baltimore, Maryland 21215-0036

**Examiner** 

Division of Vital Records, P.O. Box 68760

	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State							
	'4 □Donation 5 □ Other (Specify)	Kent Cremation	8/26/10	Smyrna, DE.							
	21. Signature of Funeral Service Licensee  M.	22. Name and Address of Fa Galena Fune 118 West Cr	rál Home of	Stephen L Schaech Lena, MD. 21635							
	23a Part 1. Enter the disease, or complications that caused shook, or hear/failure. List only one cause on each lir immediate Cause Final disease or condition	the death. Do not enter the mode of dying, such ie.									
jr.	Due to (or as	a consequence of):									
Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c	a consequence of):									
Completed by Physician/Medical Examiner	d										
hysici	1 Yes 2 No 4 Pregnant at 9 Unknown	time of death 5 Other (specify)		Month Day Year							
ed by P	Part II. Other significant conditions contributing to death be	at not resulting in the underlying cause given in Pa		bacco use contribute to the cause of death? es 2 \( \text{No} \) 3 \( \text{Probably} \) 4 \( \text{QPonknown} \)							
Complet			24a. Was a autop pertor	sy prior to completion of cause of							
a)	25. Was case referred to medical	26. Pla	ace of Death (Check only or	ne)							
ToB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatient 3 DOA Other: 4	Nursing Home 5 Resid	ence 6 Other (Specify)							
	27. Manner of Death  ↑☆Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe h	ow injury occurred							
Certification:	3 Suicide 6 Could not be determined 28e. Place of Inju-building, etc	ury - At home, farm, street, factory, office c. (Specify)	28f. Location (S City or Tow	treet and Number or Rural Route Number, n, State)							

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

63747

2540 Centreville Rd. Centreville, MD.

325 Kidwell Ave. Centreville, MD. 21617

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

Date

DHMH 17 Rev 1/2001

State Registrar

within 24 hours a

29a. Certifier

29b. Signature and title of certifier

Jeffrey Ukens,

Month, Day, Year, 0 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert Leon Utterback 10:10 AM 2010 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4812 Tuckerman Street Prince George's Riverdale Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year January 21 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 220-38-1062 67 Director Riverdale, Usual Residence of Decedent fshow 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at filed within 72 hours after death with the Maryland Director Maryland Prince George's Riverdale 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20737 4812 Tuckerman Street USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates. 1967–1969 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 UVidowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Renovation Construction 12 Department of Health and Mental myur Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be fil nt of Health and Mental is if item 27 is marked of ည Herman Edgar Utterback Emma Maude Leedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy C. Lambert / Sister 5026 59th Avenue, Hyattsville, MD 20781 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/24/2010 Maryland Veterans Cemetery Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Ragers Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic Cordiomyopathy Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by heral Vascular 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director After this certificate has been si completed filed in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and the of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar' Signatu

Ker

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D31001

Greenbelt

7500 Greenway Cntr. Dr. #430

29d. Date signed (Month, Day, Year)

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30/AM Cecelia Agnes Veihmeyer J6UST Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lanham Prince George's Doctor's Community Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea May 26, ] 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months Days Hours Min. 577-40-1936 Director 94 Usual Residence of Decedent or 28a-f show e notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 5a notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Bladensburg 1 X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? Funeral 5999 Emerson Street, Apt. #321 20710 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Máryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Catherine Schroen William Tynan Burroughs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9416 Franklin Avenue, Lanham, MD 20706 Doris C. Burroughs / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 8/18/2010 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ricenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 0 Ay 5 Medical onsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 2 0 Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an After this certificate has autopsy performed? Yes 2 2 N Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No မ Enpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I nd title of 29d. Date signed (Month, Day, Year) 132261

State Registrar 8116 GOOD LOCK POAD

LAWHAN, A10 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Sign

			For State Registrar	State of Marylan	-	artment rtificate			l Mental		ne N2 0	10	27728
	Physici /Medi		1. Decedent's Name (First, Middle, Las Min Tsi Wu	et)			_		2. Date of Month Augus	1	Day 2010	Year	3. Time of Death 4:45 p
)	Examir Funeral Director		219 <del>-</del> 82-9356		last birthday) Yrs.	S	ilver	Location of De Spring If Under 24 H Hours Mi	rs. 8. Date on. (Mont			omery 9. Birthp Coun	lace <i>(State or Forei</i> etry) <b>China</b>
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10e. Street and Number  2723 Weller Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  (Specify only highest grant Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Unknown Hsiao  19a. Informant's Name/Relationship (1)  John J. Wu/Son  20a. Method of Disposition  1 Decedent Sed (Specify only highest grant)  20a. Method of Disposition  1 Decedent Specify (1)  21. Signature of Funeral Service Licen	12. Was Decedent Ever in U. Armed Forces?  1	16a. Dece (Give life.  19b. Maili 10500  lace of Disponemetery, cre ce of He	Was Deceded If Yes, special User Spin Was Deceded If Yes, special User	209 ent of History Cubai No Occupacy done do retired,  Street a er La er of her place emete	spanic Origin? n, Mexican, Pu Specify:  tition uring most of w  18. Mother's N  Unknown und Number or ne, Potor	orking  Tame (First, M.  DWN  Rural Route N  TAC, MD  Date  Quist 21  2010  uneral H	US  or No-  16b  16b  1cddle, Maid  20854  20c  Si  come In	14. Rac Blac Specify  5. Kind of B  Own H  den Surnan  ty or Town,  Location  lver S  C.	What Coun e - Americ ck, White,  Asian usiness/Inc ome ne)  State, Zip City or To	an Indian, etc.  dustry  Code)  own, State  Maryland
8760,	Physician /Medical Examiner	ical Examiner	23a. Part1. Enter the disease, or omn shock, or heart failure. List only of the shock of the sho	b. COPD  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	n. Do not en uence of): uence of):							2030	Approximate Interval Between Onset and Death
or Vital Records, P.O. Box 6876( Physician: The law requires that the death certificate be	w requires that the death certificate been signed by the attending phy- should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown  Part II. Other significant conditions of	23c. If yes, outcome pf pregna 1	I death 3[ eath 5[	□Ectopic pre □ Other (spe	ecify)	n in Part I.	-	1 [★Yes	co use con	3 ☐ Prob	Day Year ne cause of death? nably 4 □Unknow
Division or Vital Rec	Hospital or Attending Physician: The law in 24 hours after death. Funeral Director: After this certificate has bustely filled in by the funeral director, page 2 shely filled in by the funeral director, page 2 shely filled.	dical Certification: To Be Completed	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Year)	wiedge, deat	M 28 M reet, factory,	dc. Injury Work 1  office	at ? /es 2 \sum No	1 Neath (Check of Parameter) 1 Neath (Check of Parameter) 28d. Described 28f. Locate 28f.	Residence ribe how i ion (Stree or Town, S	Prince 6 □Other injury occur and Number tand number t	prior to condeath? 1 □ Yes  er (Specify red  per or Rura	al Route Number,

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifie



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Le Le Luu, Md 1201 Seven Locks Road, #111, Rockville, MD 20854

29c. License number

MD0059794

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 16 2010 Elsie R. Wolf August 4:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Ingleside at King Farm If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 🔀 F 96 Months Days Hours Director 231-03-6553 27, 1914 Feb. Virginia Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Exar, free 1, 41st be notified at 1 Yes 2 No Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 King Farm Blvd. 20850 USA Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, I'm Medical Examination. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 录No Specify: 2 Specify: White 3 Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Max Rosenberg Leocadie Lang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca W. Fox /Daughter 9426 Bentridge Avenue, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Washington Hebrew Cong. Memorial Pk. 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/18/2010 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Addr Edward Sagel Funeral Direction, Inc. MCGreenhoot mo1597 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a con Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a consequent Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 □No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

Examiner • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and lettely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, Division of Vital Records,

the Maryland

with

Baltimore, Maryland 21215-0036

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

29c. License number

29d. Date signed (Month, Day, Year)

16/10

completely To the I within 2. 10

Registrar

170027274

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Heshmat, MD 10110 Molecular Drive, Rockville, Maryland 20855

31. Date filed (Month, Day, Year) State AUG 2 0 2010

29b. Signature and tit

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Geraldine Elizabeth Wilson 2:06 AM August 18 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner Medical Center 5. Social Security Number of Maryland Balhmore Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral | Months 1 □ M 2X □ F Days Hours 216-40-5388 68 MD Director July 27,1942 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the state of the state 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🗓 No Director MD Talbot Trappe 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code United States 21673 2835 Moneymake Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ∐Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2/17 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 5 Specify: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Clothing Manufact. Seatress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Elwood Chouncie Johns Mable Brice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2835 Moneymake Rd., Trappe, MD 21673 Herbert R. Wilson/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 😾 Burial 2 ☐ Cremation 3 ☐ Removal from State Spring Hill Cemetery 08/26/10 Easton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee Christin 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1schemic hear disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Atheroscianti Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed bours after death. burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 □ Yes 2 🖬 🗖 o 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1093030546 18,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 MD St. Baltmore Michael Chung South Greene 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan	•	artment of H		Mental Hy	giene	010	277	20
			Registrar  1. Decedent's Name (First, Middle	le. Last)		Cer	tificate of D	eatn	2. Date of De	Reg. No.	UIU	3. Time of D	<u>Z J</u>
П	Physicia Medic			arner					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Pay	201	1135	AM
	Examin		4a. Facility Name (if not institution	n, give street and numb		detr	4b. City, Town, or Bautin			4c. C	County of Deat		
	Funeral Director		5. Social Security Number 212-61-8625		. Age (In yrs. la	•	If Under 1 Year Months Days	If Under 24 Hi Hours Min			g. Birt Cod Mary	nplace (State or i intry) rland	Foreign
	nd how at	ř	Usual Residence of Decedent  10a. State 10b. County	y	10c. City	y, Town or Lo	cation	-				10d. Inside City	Limits
	farylar 8a-f sl tified	Funeral Director	Maryland Caro	line		nton						1 X Yes 2	
	a or 2 be no	io le	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Co	untry?	
	th with ms 23 must	ıner	1202 Fairfield				21629		2 11 11	US			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status  1X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	16 1/4 (2)	es? 2 X No	J:	Vas Decedent of His f Yes, specify Cuban ☐ Yes 2 🏿 No	n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		4. Race - Ame Black, White pecify: B1a	, etc.	
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Baltimore,	it. Page intment o intant: If njury or		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other	(Specify)		ing Gr	ove Cemet	ery Aug	g 21 2010	Dent	on, Ma	ryland	
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Box 68760	Jing Physician: The law requires that the death certificate be executed h.  After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Me	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or b. Due to (or c. Due to (or d.	ras a consequence of pregnant at time of own  ath but not residually a patient 2   injury, Day, Year)  If Injury - At hog, etc. (Specify,	ncy Il death 3 [ Ideath 5 [ Ideat	26. Plate 3 DOA Other 28c. Injury work?  M 26. Plate 3 DOA Other 28c. Injury work?  M 1 Yest, factory, office	ce of Death (Cr.  14 \( \text{Nursing} \)  14 \( \text{Nursing} \)  14 \( \text{No} \)  15 \( \text{No} \)	24a. Was autor performed only one)  Home 5 Resided Describe here 28d. Describe here 28f. Location (Significance)	obacco use Yes 2 2 an ssy rmed? 2 2No dence 6 [ oow injury of the firet and if n, State)	Month  e contribute to  No 3 Per  24b. Were aut prior to o death? 1 Yes  Other (Special occurred	Onset and De Wear A Mont	ath  ar  ar  ath?  nknown  ailable use of
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P.O. Box 68760	or Attending Physician: The law requires that the death certificate be executed ster death.  By A sifer death.  Jirector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Me	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or b. Due to (or d.	ras a consequence of pregnation and at time of distribution of distribution of distribution of examination of e	ncy Il death 3 leath 5 leath 5 leath 5 leath 5 leath 5 leath 5 leath call lea	26. Plate 3 DOA Other work?  M 1 Yeet, factory, office	ce of Death (Cr.  4  Nursing at (Yes 2 No No death occurre time, death occurre time, date and place in number	24a. Was autop performed on the care of th	pobacco use Yes 2 2  an Say rmed? 2 2  Street and I  m, State)  use(s) and nd place, a e cause(s) a  29d. Date	Month  e contribute to  No 3 Pe  24b. Were aut prior to c death? 1 Yes  Other (Special Control	very Day Yes  the cause of dea bably 4 Ur  opsy findings avi ompletion of cau 2 No  fy)  al Route Number  ted. ause(s) and mannitated. Day, Year)	arth  ar  ar  ath?  nknown  ailable use of
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P.O. Box 68760	4 hours after death.  4 hours after death.  5 To a substitute of the continuation of t	Medical Certificate: To Be Completed by Physician/Me	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or local points)  23c. If yes, outcome to (or local points)  4   Pregnary of Unknown to (or local points)  4   Pregnary of (or local points)  28a. Date of (or local points)  28a. Place of building  3   Nurse Practioner: To the basis  3   Nurse Practioner: To or local points  4   Pregnary of the points  4   Pregnary of the pregnary of the points  5   Pregnary of the pregnary of the points  6   Pregnary of the pregnary of the points  6   Pregnary of the pregnary of the points  6   Pregnary of the pregnary of the points  7   Pregnary of the pregnary of the points  8   Pregnary of the pregnary of the points  8   Pregnary of the pregnary of the points  8   Pregnary of the pr	ras a consequence of pregnant at time of own  and the best of my knowledge of examination of examination of the best of my  of death (Item  of as a consequence of pregnant at time of own  and at time of own  and the best of my knowledge of examination of the best of my  of death (Item	ER/Outpatier 28b. Time of injury me, farm, streedge, death of and/or invest with knowledge, of the control of t	26. Plate 3 DOA Other (Specify)  28c. Injury work?  1 Yeet, factory, office  cocured at the time, igation, in my opinior leath occurred at the 29c. License DOG3	ce of Death (Cr. 4	24a. Was autop performed on the care of th	obacco use Yes 2 2 an psy yrmed? 2 2 No dence 6 E oow injury of the control of the control we(s) and nd place, a e cause(s) a 29d. Date	Month  e contribute to  No 3 Pr  24b. Were aut prior to o death? 1 Yes  Other (Special occurred  Number or Run  manner as sta nd due to the o and manner as signed (Montri	onset and De Wear  A Mont  very Day Ye.  the cause of dea obably 4 Urr opsy findings avaionpletion of cau. 2 No  fy)  al Route Number  ted. ause(s) and mannistated.  Day, Year)	arth  ar  ar  ath?  nknown  ailable use of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 WELCH MIERING 0420 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 5 Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July 2, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min. Maryland 78 Director 932 577-42-0717 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No Maryland St. Mary's Charlotte Hall 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20622 USA 38373 New Market Turner Rd. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) al Hygiene. Real Estate Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Development years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file hand Mental F 2 Charles B. Delancey Isabelle M. Weber permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38373 New Market Turner Rd., Charlotte Hall,MD 20622 Robert L. Welch/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 8/20/10 Clinton, Maryland . Signature of Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a, Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death las been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2. No Other: ည 1- Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ure and title of Perti ٥ 29c, License number ED) 10 Name and address of pe

DHMH 17 Rev 7/2009

State Registrar Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 20 TO GILBERT S. WILLIAMS 6:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Clinton Nursing & Rehabilitation Center Clinton If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Months Days Hours Min. (Month, Day, 417-62-4572 Director 61 Auburn, November 1948 Alabama Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 X Yes 2 No DC District of Columbia Washington 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Id be filed within 72 hours after death with the Mental Hygiene. In arked other than "natural", or items 23a oatic event, the Medical Examiner must be Funeral 5740 13th Street, NW, 20011 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ğ 1 ₺ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) onday (0-12) College (1-4 or 5+) Janitor Hospital permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Shepherd Ophelia Hagens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5740 13th Street, NW, 3B, Washington, DC 20011 Deloris Mixon - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Westview Cemetery D8/17/2010 Auburn, Alabama 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a, Part 1. Enter the disease, or conflicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ MALIGNANT NEOPLASM BRONCHUS AND LUNG disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** HIV + Sequentially list conditions, Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying physician and the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 2 No 9 Unknown sate has been signed bage 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð HUMAN IMMUNODEFICIENCY VIRUS Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of death? MALIGNANT NEOPLASM BRONCHUS AND LUNG 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛣 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral Director; After this filled in by the funeral dir 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State

DHMH 17 Rev 7/2009

Registrar

nton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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AUG 2 0

29d, Date signed (Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14, 2010 A M 8:42 August Rufus Α. Williams Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 4-29-1929 Country) 81 Director 579-36-6599 Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD Prince George's Upper Marlboro 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4300 Canyonview Drive 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces?

1X Yes 2 No 1952-Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed 1959 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) UPS Driver Delivery service/ Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Esaw Williams Gabriella (Unknown ) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Gertrude Williams ( wife )</u> 4300 Canyonview Drive Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl Date 20c Location - City or Town State Chelten cemetery crematory or other place)
Chelten cemeters retreated a 8/24/2010 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cheltenham, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ) Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if my leading immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe hours after death.

neral Director: After this certificate I
d filled in by the funeral director, pag 2 🗌 No Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 2 Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination allows investigation, in my opinion, weak, second allowed by the cause (s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D 0063998

State Registrar 7503 Surratts Road

Clinton, MD 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Sign

Nachnani Manesh,

31. Date filed (Month, Day, Year AUG 1 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 105 0010 A M Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington montgomer advent 7. Age (In yrs. 8. Date of Birth . Month. Pay, Social Security Number Birthplace (State Country) If Under 24 Hrs **Funeral** Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertalt Hygiene. Important: If item 27 is anarked other than "natural", or items 23a or 28a-f sho may injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director Jasning Yes 2 No 10g. Citizen of What Country? by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian Mever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2000 Specify: 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) NONE College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ UNKNOWN Lillian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 名1 RiggらRD NE #109 WQかhingtoN, DC 19a. Informant's Name/Relationship (Type, Print) ter Pryo 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cem 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 814 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death monal Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Records, Completed 24b. Were autopsy findings available 24a. Was an cate has l autopsy performed Yes prior to completion of cause of death?

1 Yes 2 No 24 hours after death.

Funeral Director: After this certificate is leted filled in by the funeral director, page Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 20 No ဂ္ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tanmina K. Hhmed 831 University university Blyd East Suite 27- Silver Spring, mb State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ AUGUST 11, 6:50 $A^{M}$ BOBBY YOUNG Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S CRESENT CITY NURSING HOME HYATTSVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🕱 M 2 🗆 F Hours (Month Day Year) 12/27/1940 Weptumpka, AL Director 69 466-66-6554 Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🕅 Yes 2 🗆 No Maryland | Prince George's Temple Hills 10e. Street and Number 10g. Citizen of What Country? Funeral 20748 Unites States <u>3631 Dunlap Street</u> Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 🙀 Married Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Central Office Technician Verizon 1 and 2 should be filed w if Health and Mental Hygi item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ovella Berry Walter Young 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Regina Y. Young / Wife 3631 Dunlap Street Temple Hills, Maryland 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 5 Bunal 2 Cremation 3 Removal from State injury o 4 Donation 5 Other (Specific 8/20/2010 Maryland Veterans Cheltenham, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. any 1 MOLDES 5538 Marlboro Pike Forestville, Maryland Part 1. Enter the disease, of complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ASPIRATION PNEUMONIA Medical resulting in death) Due to (or as a consequence of) Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami sician and burial-transit PARKINSON'S DISEASE that initiated events resulting in death) Last attending physician Physician/Medical death certificate be as the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No of Vital 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2X No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural (Month, Day, Year) 5 Pending Division s after death. Il Director: Af 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined To the Hospital of within 24 hours at To the Funeral D completed filled in Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature nd title of co 29c. License number 29d. Date signed (Month, Day, Year)

Box 68760

P.O.

State Registrar

30. Name and addess of person who con

Tonya Hardy-Jones

DHMH 17 Rev 7/2009

leted cause of death (Item 23a) (Type, Print)

D 0058095

4409 East West Highway Hyattsville, Maryland

August 12, 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 1:30 Ам 2010 26 18, August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Layhill Center Silver Spring Montgomery 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Year) Hours 1 □ M 2 🛛 F Days 199-14-6997 85 Yrs. April 15, 1925 PA Kingston, Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No Maryland | Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4917 Lasalle Road 20782 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: White Specify. 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenters Union 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (Unav.) John Ishley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce L. Mason / Daughter 4220 Nicholson Street, Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 8/19/2010 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Ragus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OSI りつしてら disease or condition resulting in death) Due to (or as a consequence of): eumo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mon Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy

**≱**hysician /Medical Examiner

Department of Health Important: If item 27 any injury or other trong.

permit.

**Physician** 

/Medical

Examiner

10a, State

Director

Funeral

≥

Completed

Be

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Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intent of Health and arked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

ed other than "natural", or items 23a or 28a-f show event, the Medical Evantions must be notified at

and burial-tran physician the attending p the ģ signed I peen cate has t certificate

this funeral After death.

the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical ş Completed Be မှ Certification: Medical

Division of Vital Records, Vithin 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

29b. Signature and title of certifier

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes

Other: 4M Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 No

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zaster BIVD Baltinon MD 2122 Waltono 1245

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

20 31. Date filed (Month, Day, Year) AUG 2 0 2010

25. Was case referred to medical

5 Pending

investigation 6 Could not be determined

1 | Yes 2 | XXX |

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier (Check only one)

2 Accident

4 Homicide

32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 30. 2010 8:30P MARGARET MARY BURKE ALBERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **kaminer** Baltimore Baltimore Oak Crest Care Center Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Vonths Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX 1 1/20/1915 ar) 111999898 Director 338-12-8328 94 Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 200 No Maryland Baltimore Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther Blvd 21234 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXVo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 3XX Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche Van Sykel Thomas Francis Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14813 Manor Road Monkton, Maryland 21111 John J Albert Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State 09/02/2010 Baltimore, Maryland New Cathedral Cemetery ☐ Donation 5 ☐ Qther (Specify) nature of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or co shock, or heart failure. List or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death one cause on each line. Immediate Cause (Final Physician/ Kesperatory disease or condition resulting in death) Medical Due to (or as a cons -- nce of) Examiner Nodule Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🔲 Yes 2 No 3 □ Probably 4 □ Unknown iis certificate has been si director, page 2 should t 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: A Nursing Home 5 - Residence 6 - Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 5 Pending 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 2010 R171944 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michealle G. Harrison CKNP MSN 8800 Walther Blvd, Parkville MD 21234 31. Date filed (Month, Day, Year) SEP 0 7 2010 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010<sup>Year</sup> Physician/ AUGUST LOMI AKINFOLARIN 11:35 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day FEB 21 Days Hours Min 1 XM 2 F Months NIGERIA Yrs Director 214-71-7498 Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 No MD PRINCE GEORGE'S CHEVERLY ms 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6151 64TH AVENUE 20737 USA Apt 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ŏ þ 1 Never Married 2 Married 2 **X**No Yes Baltimore, Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 Yes 2 X No Specify. "natural", Specify Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) COUNSELOR PRIVATE permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any minry or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည U/K U/K 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 99 HERRINGTON DRIVE UPPER MARLBORO, MARYLAND 20774 ROWLAND AJIBADE/BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State RESURRECTION CEMETERY 9/3/2010 CLINTON, MARYLAND ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fundal Service Lice 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No eral Director: After this certificate I filled in by the funeral director, pag 1 ☐ Yes 2 🔀 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 Yes 2 💢 No မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 \( \text{Yes} \) 2 \( \text{No} \) iniury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D0059981

State Registrar DHMH 17 Rev 7/2009 mutemil

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3801 HOSPITAL DR. CHEVERLY, MARYLAND 20785

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32. Registra s Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death : 21 PM Month O 3 Physician/ AM S 10 ORA 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NA Levindale Nursing Home Baltimore 7. Age (In yrs. last birthday) 86 Yrs. If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Social Security Number 216 – 20 – 5023 **Funeral** Country 1 M 2 Months Hours Min 01<sup>Mo</sup>0 5<sup>Day</sup> 2°4" Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 □ No NA Baltimore MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral USA 1805 Baker Street 21217 14. Race - American Indian, Black, White, etcAfrican 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 1 Never Married 2 Married 1 Yes 2 X No þ 21215-0036 1 ☐ Yes 2 No Specify: SpecifyAmerican 3 → Widowed 4 □ Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Social Security al Hygiene. College (1-4 or 5+) mentary/Seconday (0-12) th Grade 12th Clerk Administration Be Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Smith Andrew Smith Mammie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121719a. Informant's Name/Relationship (Type, Print) 1805 Baker Street Baltimore, Maryland Dennis Adams-Son Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Garrison Forest 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Owings Mills,MD D9-09-10 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licent 638 N. Gilmor Street Baltimore, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complica Interval Between Onset and Death Immediate Cause (Final EMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician by Physician/Medical Box 68760 use as IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No atter for u Day Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other Scecily 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. injury 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST DAVID ALLMOND 2010 9:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GOOD SAMARITAN NURSING CENTER BALTIMORE Birthplace (State or Foreign Country) Funeral Year If Under 24 Hrs. 8. Date of Birth 02-07-1922 Director 229-18-7854 88 VA Usual Residence of Decedent or 28a-f show 10a. State 10b Counts items 23a or 28a-f sho ner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2819 W. LAFAYETTE AVENUE 21216 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK "natural", 3 X Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. SUPERVISOR BETHLEHEM STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ be f ORA GHOST DAVID H. ALLMOND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 .. Page 1 and 2 sh tment of Health a tant: If item 27 is permit. Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr 1811 BURNWOOD RD. BALTIMORE, MD MICHAEL\_ALLMOND/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) ARBUTUS MEMORIAL PK. 9-8-2010 BALTIMORE, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licenses JAMES A. MORTON & SONS F.H., INC. a 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Meta Cancer Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for uses as the burlar-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No 1 Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

Terrance 6.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

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State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Clate of Marylan	•	rtificate of		Reg. N		
	Physici	an	1. Decedent's Name (First, Middle, Las	st)	ρ	a ttain	2.		ay Year	3. Time of Death
mark.	/Medic	cal	Celeste  4a. Facility Name (If not institution, giv	e street and number)	I.	oetter	ပြင Location of Death	1	02 2010 c. County of Dea	4:52 A M
ا اسپ	Examir	ier	Johns Hopkins Ho				Baltimore		*	I/A
N	Funeral Director		5. Social Security Number 113-64-9025 6. S	7. Age (In yrs. 43	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea 11/13/66	r) 9. Bir	thplace (State or Foreign ountry) NY
	Maryland F show	tor	10a. State MD 10b. County Montgo		y, Town or Lo	cation ver Sprin	ngs			10d. Inside City Limits  ¥☐ Yes 2 ☐ No
	h with the 23a or 28a 81 te noti	al Director	10e. Street and Number 8811 Colesvi	lle Road		10f. Zip Code	)910	10g. C	Citizen of What Co	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Maryland Exarcia art aust be notified at once.	by Funeral	11. Marital Status  1  Nover Married 2  Married 3  Widowed 4  Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No	ispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	
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121	within iene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Manag	er of Dev	auding most of working f) relopment O	peration	s Americ	an Lung
land 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Earl Better				18. Mother's Name (F Betty Br	irst, Middle, Maide	ASSO	C.
Baltimore, Maryland 21215-0036	and 2 shouealth and An 27 is maiser trauma		19a. Informant's Name/Relationship ( Betty Better	/ Mother	2807	Westingh	and Number or Rural R Nouse Road,	Noute Number, City Horsehea	or Town, State, . ads NY	Zip Code) 14845
timore	Pages 1 Iment of H Iant: If iter		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 🖔  4 ☐ Donation 5 ☐ Other (Specify	y) WO	odlawn	sition (Name of natory or other place Cemetery	9/7/2	010 E		NY
Ball	permit Depart Import any inj once.		21. Sign ture of Fire ryl Saving Licer	SeeVictor P. Do	da දී 1	harles L. 501 East	ss of Facility Stevens F Fort Avenue	uneral Ho e, Baltin	ome, Inc nore MD	<b>2</b> 1230
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Zi.	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		ot 3 🗆 DOA Othe	26. Place of Death (C			
on of	ding Phys th. After this funeral dir	ion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	y at 28d	5 ☐ Residence  I. Describe how inj		ecify)
Divisio	Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the i	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, stre		Yes 2 □No 28f.	Location (Street a City or Town, Sta		ural Route Number,
	To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by the	Medical C	29a. Certifier (Check only one) 1 ☐ Certifying Ph	ysician: To the best of my kno niner: On the basis of examinal and manner stated.	wledge, death tion and/or in	n occurred at the tirvestigation, in my o	ne, date and place, and pinion, death occurred	d due to the cause at the time, date a	(s) and manner a nd place, and du	s stated. e to the cause(s)
	To th Vithir To th Comp	Me	29b. Signature and title of certifier	, 0 12		29c. License		29d. C	ate signed (Mont	th, Day, Year)
			- Filk	· Kanley		RES	-000	Sep	tember	02 2010
			30. Name and address of person who of ARVIND K. P	completed cause of death (Item ANDEY 32. Redistrar's Signat	23a) (Type, I	The Johns	Hopkins Hos	spital Ba	iltimore, l	MD 21289
	Sta Registr		SEP 0 7 2	32. Registrar's Signat	A. A	have				

DHMH 17 Rev 1/2001

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	Dhysisis	m/	Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physicia Medic	al	CLARA WASHINGTON	BOWE	NS	1		August	31 2010	
ز	Examin	er	4a. Facility Name (if not institution, give street and r Washington Adventist H	· .		4b. City, Town, or Takoma		th	4c. County of Dea	
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday		If Under 24 Hrs Hours Min		h 9. Bi	irthplace (State or Foreign
	Director		191-16-1832	87	Yrs.	World bays	Tiours Will	Mar. 3I	1923	PA
	and show dat	lor	10a. State 10b. County	10c. City,	Town or L	ocation				10d. Inside City Limits
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	ith the 3a or t be n		10e. Street and Number			10f. Zip Code			10g, Citizen of What C	ountry?
	eath w	Funeral		ecedent Ever in U.S.	13	. Was Decedent of Hi	spanic Origin? (S	Specify Yes or No-	USA 14. Race - Ame	erican Indian.
Maryland 21215-0036	e 1 and 2 should be filed within 72 hours after death with the Maryland tof Heath and Mental Hygiene.  1 of Heath and Mental Hygiene.  1 other Iz is marked other than "natural", or items 23a or 28a-f show frother traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 7 Yourseld 1 Fyes,	Forces? es 2 🖾 No Give Dates.		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puer	to Rican, etc.)	Black, Whi	
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E E	Page 1 ment of I ant: If it ury or of		1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	om State cei	metery, cr	oln Cemete	· !	1	Brentwood	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Figneral Service Licensee	Party)	1		s of Facility Funeral		Maryland	0746
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-miles	hysician/		Immediate Cause (Final disease or condition	KTUSKID	SCL	exotec.	MODEL	DESEA	30T	Interval Between Onset and Death
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3760	certificate be executed inding physician and use as the burial-transi	Aedi	d							
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Hecc	The law ate has page 2	Completed						24a. Was a autop perfor 1 \(\sum \) Yes	sy prior to death?	utopsy findings available completion of cause of ss 2 \square No
I a	sician: certific rector,	Be	25. Was case referred to medical examina?  1 Yes 2 □ No Hospital:			Otho	ace of Death (Che			
ر ح	g Phys er this eral di	e: 10	27. Manne of Death 28a. Da		8b. Time	ent 3 🗆 DOA	4   Nursing I		ence 6 Other (Spec ow injury occurred	cify)
- 0	ath. ir: Afte	ficat	2 Accident Investigation	onth, Day, Year)	injury	work	? Yes 2 □ No		····,,	
DIVISI	or be nospiral or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	l Certificate:		ce of Injury - At hom Iding, etc. (Specify)	e, farm, s	treet, factory, office		28f. Location (Si City or Town	reet and Number or Ru n, State)	ıral Route Number,
	ne Hospi in 24 hou he Funeri pleted fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the b 3 Certifying Nurse Practione	pasis of examination a	and/or inve	stigation, in my opinio	n, death occurred	at the time, date ar	nd place, and due to the	cause(s) and manner stated.
	Voirt Con		29b. Signature and title of certifier	7		29c. License	57.61		29d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who completed ca  Don Michael Coleman I			Print)	. Takor	ma Park .	MD	
	Stat	е	31. Date filed (Month, Day SEP 0 7 2010)	Registra s Signatur	re	A AVE	- Idroi	9		
	Registra	ır	JLF V 1 2010	Leneva	1 2.	parker				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 27742 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September<sup>Da</sup>4 2010 1:45a Wesley Cole Byron Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death N/ABaltimore Future Care Homewood 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Sept. 18, Year 925 Director 219-10-3844 84 Maryland Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or I Examiner must be Funeral 600 Light Street Apt 501 21230 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: "natural", 3 Divorced 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Janitor Pharmaceuticals of Health and Mental Hygi item 27 is marked othe other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jonsen Charles Henry Byron 0lga Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other traconce. Lois Krok, Niece 8227 Sherbrooke Court, Millersville, Maryland 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 09/07/10 Baltimore, Maryland 21. Signature of Juneral Service License Amanda Heaston 22. Name and Address of Facili Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryalnd 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ eumoni disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Error Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year the a detached 9 Unknown Unknown is been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ allure Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s this certificate has performed Hospital or Attending Physician: The 2 🗌 No Yes 2X No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 Pending 1 X Natural 1 Yes 2 No Accident
Suicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours Medical 29a. Certifier 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practionar To the basis of my incoming a first population of the time, date and place and due to the cause(s) and manner stated. (Check within 2 To the 1 29b. Signature and Aftle of Certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael ( Fally a Wrence 31. Date filed (Month, Day, Year) State

J DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-06646 Shailesh Bhandari State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day September 3, 2010 Medical Examiner Shailesh Bhandari 1002 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore N/A5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or Foreign **Funeral** Country) Nepal Months Days Hours Min Director 112-80-6850 49 05/07/1961 1 X M 2 F Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatte event, the Medical Examiner must be notified at once Montgomery Boyds rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18425 Polynesian <u></u> Lane 20841 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Nepali If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2X No Yes 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 X No specify: Specify: Indian ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Census Bureau Employee Dept. of Commerce Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daya Ram Bhandari Pyakurel 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Koirala, Brother-in-law 11941 Thurloe Drive, Lutherville, Maryland 21093 Kiran 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Metro Crematory,Inc. 9/5/2010 Donation 5 Other Specify: Baltimore, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21 Signature of Funeral Service Licensee Man a leaston 101 Frederick Road, Catonsville, Maryland 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Complications of acute gastroenteritis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the burial - transit requires that the death certificate be executed Physician/Medical XUNPENDED AMF1452 #9 Per FH G907 9/10/10 Jh/ 23a, PII, 27, per E g908 10/22/10 TT Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 V Unknown Diabetes mellitus; Hypertension Completed been 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? ✔ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 🗹 Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA After this 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Pending 1 Yes 2 No death 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 4 Homicide

within 24 hours after death To the Funeral Director:

29a. Certifier 1

29b. Signature and title of certifier

Zabíullah Ali, M.D.

31. Date filed (Month, Day, Year) SEP 0 7 2010

Medical

State

Registrar

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

September 4, 2010

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Pestate of Maryland 1 be partition of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13a11 Physician/ Month :25 D eptember of Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death lizabeth Baltimore ursing Security Numbe Year If Under 24 Hrs. (In vrs. last birthday If Under 8. Date of Birth Birthplace (State or Foreign Country) MD **Funeral** Aug Year 1922 1 M 2 X F Months Days Mir Director 218-18-3419 88 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel Severn 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21144 7714 Buckingham Nursery Drive USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Completed 3 🛚 Widowed 4 🗆 Divorced Specify: Mental Hygiene. marked other than "natura matic event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Wilson Widerman Ella Mildred <del>Luke</del> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Satosky Daughter 7714 Buckingham Nursery Drive; Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Olive Cemetery Mt. 9/7/2010 Randallstown, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. signature of Funeral Service Lig 1630 Edmondson Avenue; Catonsville 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or Approximate Interval Between Immediate Cause (Final Onset and Death Physician em-en disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner distast ronar Ó Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or iinjury ria that initiated events resulting in death) Last Due to (or as a cons Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnam.
Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical examiner? Be completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 2 🔏 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Tes 2 🗌 No Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29c, License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3320 venue 2122 enson

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Jok, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day, DONALD EUGENE BOWMAN 2010 1:35 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER Towson Baltimore County If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 80  $JuIy^{(Month, Day, Qay, Qay)}$ Ohio Director 293-22-3185 1930 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Marvland Baltimore County Timonium 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2417 Eastridge Road 21093 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 52 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event; the Medic once. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive /Broker Investments Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Bowman Delia Sink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2417 Eastridge Road, Timonium, Maryland 21093 Mary Louise Bowman (Pers. Rep.) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Angle Cemetery 9/11/2010 4 ☐ Donation 5 ☐ Other (Specify) Wirtz, Virginia 21. Signatur of Frais we live see MINCHELL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence or) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 🗆 No tor: After this certificate has been signed by the the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Funeral Director. After this certificate h completed filled in by the funeral director. performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? Investigation 1 Tes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital c 24 hours at Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only Q Sig nature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2010 stenso 6 and address of person who completed cause of death (Item 23a) (Type, Print) M DAY NOCHED AYAAAN State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 12:15 A M September 3, 2010 Mildred Ruth Berger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 M 2 KF Director 99 July 30, 176-34-5006 1911 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified 1 X Yes 2 No Director Gaithersburg Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 301 Russell Avenue 20877 **IISA** Funeral ural", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. Completed by 3 ₩idowed 4 Divorced White 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I Frank Kohler Mary (Unknown) ဂ္ Health and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Berger/Son 22221 Overview Lane, Boyds, Maryland 20841 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David
Memorial Gardens Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/7/2010 Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility National Funeral Home Ul CGreekhill 7482 Lee Highway, Falls Church, Virginia 22042 MO1597 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hysician Laure resulting in death) /Medical Due to (or as a consequence of): Examiner seration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (of as a consequence of): Examiner Esty hazard dysmotil
Due to (or this a consequence of): and Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a. Was an 25. Was e referred to medical examiner? director. Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

certificate be exec Box ( o Records, Vital Physician: Division or filled in by the funeral or Attending s after death To the Hospital within 24 hours a To the Funeral C

iled within 72 hours after death

Maryland 21215-0036

Baltimore,

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

and manner stated.

29c. License number

1 E/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 2) a) (Type, Print) OI RUSSELL AVENUE (4. ROBERT BIRSCHOALOK M) GALTHERSBURG, ULS 20877.

31. Date filed (Month, Day, Year) 32. Registrar's Signature

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27747 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jerome Paul Baroch, Sr. September 2010  $P^{M}$ 11:59 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 6. Sex 1 M 2 □ F . Age (In yrs. last birthday) If Under 1 Year Jf Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Months 212-09-1854 92 May 1918 Director Yrs Baltimore Usual Residence of Decedent or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Harford Forest Hill 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 2414 Maxa Meadows Lane 21050 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. "natural", or ite 1944ģ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify. 3 Nidowed 4 □ Divorced Specify: White 1945 Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ntal Hygiene. ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Production Engineer 12 Be Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James L. Baroch Marrie Uhlik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jerome P. Baroch, Jr. (Son) 472 MacEwen Dr. Osprey, FL 34229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept. Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Carrison Forest MD Veteran Cenetery 4 Donation 5 Other (Specify) 2010 Carrison, Maryland Signature of Funeral Service Licenses (Jeffrey Testerman M01543) 9/3/10 <sup>22</sup> Name and Address of Facility Plane & Cremation Services — Bel Air 3 Newport Drive Forest Hill, Maryland 21050 WAR CHEER NPPROVED BY MESOCAL EXAM Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Conset and Death Immediate Cause (Final Physician/ Muccardia disease or condition Medical resulting in death) (or as a consequence of Examiner shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burlal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant Box ( 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ubdural hematoma secondary to motor vehicle accident Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 No Vita or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify After this Division of funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🗌 Yes Accident 08-16-2010 15:51 PM 2 🗹 No Investigation 6 Could not be Motor Venicle Accident 24 hours after deat Funeral Director; 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Upper Chesapeake Medical Center 500 upper Chesapeake Drive Bel Air, mo Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of co 29d. Date signed (Month, Day, Year) FF1440623 10 oppleted cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive Bel Air, MD 21014

DHMH 17 Rev 7/2009

State

Registrar

M800334366

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month > KIN 20/0 eptember Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 8096 Quarterfield Knoll Road Severn Anne Arundel Co. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Oct. 1, 1926 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Maryland Director 219-10-2058 83 Yrs Oct. Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 28a-f 1 Yes 2X No Anne Arundel Co Severn 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 8096 Quarterfield Knoll Road 21144 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3√Widowed 4 □ Divorced Completed Specify. Year or Dates. WWII White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any injury or other traumatic event, the Markin once. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marion Watts Beatrice Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Douglas Marion Oxenham/Son 108 Disney Avenue Pasadena, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/5/2010 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, Maryland . Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Ave SW, Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ oronary disease or condition resulting in death) Medical Due to (or as a consequer ce of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1701 24a. Was an autopsy performed?

1 Yes 2 (No demia Ynerlini 1 🗌 Yes 2 🗆 No 25. Was c se eferred to edical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A eleted filled in by the fu Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D55391 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 11 MD 3320 IM5m

DHMH 17 Rev 7/2009

State Registrar 31. Date filed Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08-29av 2010Year Irene Catherine Burnopp 3:30 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Med. Center Glen Burnie Anne Arundel . Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth 1 M 2XXF Days Director 216-34-5347 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD Anne Arundel Severn 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 Funeral 1346 Sleepy Hollow Road 21144 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cabinet Assembly Line Person Cabinet Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Wallace Anna Zwiycki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Bynum H. Burnopp - husband 1346 Sleepy Hollow Road, Severn, Maryland 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Mem Prk. 109-02-2010 4 Donation 5 Other (Specify) Elkridge, Maryland Signature of Funeral Service Lices 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., inc., 7250 Wash Blvd., Elkridge, MD 21075 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final On t and Death Physician/ disease or condition Medical resulting in death) to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami tran that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year detached 9 Unknown 9 Unknown signed by ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performed? Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 1 Other: 1 Yes 1 Inpatient 2 FER/Outpatient 3 IDOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident 1 ☐ Yes 2 ☐ No Investigation completed filled in by the Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurs id at the time, date and place, and due to the cause(s) and mainer as state 130 2010 Greae M. ALTO. 30. Name and address of person who completed cause of death (Item 23a) Type, Print) PASADRNA, MD 21122 8021 CHIB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Babazadel Month Year 20/0 ( spach 0520M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Year) 10,1963 1 □ M 2 😾 F Days Hours Min North Dakota 292-64-2869 Yrs Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Howard Columbia 1 Yes 2 No ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 5175 Eliots Oak Road 21044 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 X Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced of Health and Mental Hygiene. Item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Technical Writer Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alspach Bonnie Vandeberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. 5175 Eliots Oak Rd. Columbia, Maryland 21044 William Babazadeh (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)

Mt. Calvary Cemetery 08/30/10 1 Durial 2 Cremation 3 X Removal from State Mt. Vernon, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 5555 Twin KNOIIs Signature of Funeral Service License Homes Inc. Rd. Columbia, Maryland 21045 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death lock, or heart failure. List only one cause on each line Immediate Cause (Final Wetost Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. E. ler Underlying Cause (Disease or iinjury Due to (or as a consequence of) een signed by the attending physician and nould be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 Tes een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy Yes 2 N 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🗷 No ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After Natural
Accident
Suicide
Homicide injury 5 Pending 1 Yes 2 No. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year, 2010 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Hosptel. oward Genera 2. Registrar's Sign State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Edward Raymond Bounds 28,2010 2020 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Rehabilitation & Nursing Cto Wicomico Salisburu If Under 1 Year | If Under 24-Hrs. 8. Date of Birth (Month, Day, April 3, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days 1X M 2 □ F Maryland Director 86 218-16-8158 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Wicomico Salisbury 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1713 Woodholme Court 21840 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2x Married 1 ☐ Yes 2 🔯 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Completed by 3 Widowed 4 Divorced "natural" event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. 12 postal clerk Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if item 27 is marked or other traumatic ev Edward Raymond Bounds Nanie Selby ٩ permit. Pages 1 and 2 shoul Department of Health and M Important: If Item 27 is marl any injury or other traumations. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Bounds - wife 1713 Woodholme Court; Salisbury, MD 21840 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Si mature of Funeral Sovice Licer Director 655 W. Baltimore Street; Baltimore, MD 21201 at raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, such that it is a cardiac or respiratory arrest, such that is a cardiac or respiratory arrest. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate use (Final disease or con resulting in death) **Physician** 0 100 /Medical Tie to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy 2 100 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifie

William

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.M.D.

Kobin

IVIC

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29d. Date signed (Month, Day, Year)

10-06604 Brian Brashears Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	C	Certificate	of De	eath			Reg. No.	
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last)		BRA	520	PAR	5	2. Date of D Month Septem	eath Day Yea ber 1, 2010	3. Time of Death 1401 hrs
		4a. Facility Name (if not institution, give Johns Hopkins Hospital	street and number)			ity, Town, or Itimore	Location of De	eath	4c. County of	f Death
Funeral Director		5. Social Security Number  2/3-90-03/4  Usual Residence of Decedent		s. last birthday	_	Under 1 Year onths Days		Min A	30,1977	9. Birthplace (State or Foreign Country)
and show any nce.	o	10a. State 10b. County	10c. C	BA1		ire				10d. Inside City Limits 1 Yes 2 No
eath with the Maryland items 23a or 28a-f show ust be notified at once,	Director	10e. Street end Number 335 5. Bou	Idin 5	tree	10f.	Zip Code	224		10g. Citizen of Wh	at Country?
P 등 의	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No. Yes Give Year.	0	If Yes, sp		, Mexican, Pue	( Specify Yes or terto Rican, etc.)	White	- American Indian, Black, , etc.    
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after nrent of Health and Mental Hygiene.  Tant: If iten 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	eted by	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	or Dates:	) 16a. Dece	dent's Us most of	ual Occupati working life.	ion (Give kind DO NOT use	retired)	Specify:	siness/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Completed	17. Father's Name (First, Middle, Last)	1	7	un	CMP	104e	me (First, Middle	, Maiden Surname)	uployed
MD 21215-00: d 2 should be filed with th and Mental Hygiene n 27 is marked other te	To Be	17. Father's Name (First, Middle, Last)  Charles  19a. Informant's Name/Relationship (Typ  SANDAK K. Br	e, Print) 21224	19b. Ma	Ing Addr	ress (Street	S A	or Rural Route N	LAY umber, City or Town	DEAL State, Zip Code) to Md 21224
of 1 Fi	- 1	20a. Method of Disposition	20	b. Place of Dis	osition (	Name of cerr	netery,	Date	20c. Location -	City or Town, State
Baltimo permit. Pag Department Important: injury or ot	f	1 Burial 2 Cremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service License 23a. Part I. Enter the disease, or complications of Funeral Service on and failure. List only one cause on and	Rann	OEST A	Name a	and Address	of Facility -	Tough .	NZAVA	UNO JEFH.
Physician /Medical	- 1	landre. List only one cause on each	ations that caused the dealine.	ath. Do not ente	er the mod	de of dying, s	such as cardia	c or respiratory a	rrest, shock, or hear	t Approximate Interval Between Onset and Death
Examiner		an annualition and things is doubted.	e to (or as a consequence	e of):						
	miner	if any, leading to immediate Du cause. Enter Underlying Cause (Disease or injury that initiated C	e to (or as a consequence e to (or as a consequence	,						
executed an and al - transit		d	AMENDED			····			i i	
8760, ufficate be exended physician as the burial		F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome of pr		Catal day	2 F	Ectopic prec	anancu.	23d. Date of d	•
cords, P.O. Box 68:  law requires that the death certifines has been signed by the attending.  2 should be detached for use as:	<u> </u>	1 Vos 2 No 0 Hatmann	Pregnant at time of Unknown	donth	retaidea Other (S		Ectopic preg	gnaricy	Month	Day Year
S, P.O. uires that the n signed by	ਨ	Part II. Other significant conditions co	entributing to death but no	t resulting in th	e underly	ing cause giv	ven in Part I.	1Ye	es 2 🗸 No 3	ute to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. Box 68760, ra after death certificate be executed as after death.  The law requires that the death certificate be executed as a first death.  The law requires that the after death certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transition of the control of	Completed								psy pri	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Vital Rechysician: The this certificate al director, page	10 Be	25. Was case referred to medical examiner?  1 Yes 2 No	pital: 1 Inpatient 2	✓ ER/Outpatie	ent 3		of Death (Checother)	ck only one) sing Home 5	Residence 6	Other:
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director.		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury FOUND: Sep 1, 2010	28b. Time of FOUND: 1320 hrs	of Injury	28c. Injury	at Work?		how injury occurred	1
Division  To the Hospital or Attenwithin 24 hours after death within 24 hours after death completely filled in by the	Ę	3 Suicide 6 Could not be determined	28e. Place of Injury - At (Specify) Novelty S		reet, facto	ory, office bu	ilding, etc.	or Town,		or Rural Route Number, City Baltimore , Md
To the Howithin 24 Properties To the Function Completely	edicai	nne) 2 Medical Examiner: Or	To the best of my knowle the basis of examination and manner stated.		ation, in	my opinion,	death occurred		and place, and due	e to the cause(s)
•		9b. Signature and title of certifier  P. M. D	E for		2	29c. License O.C.M			September 2	( <i>Month, Day,</i> Year)
P			Medical Examiner	111 Penr	Street	t, Baltimoi	re, MD 212	01		
Stat Registra		11. Date filed ( <i>Month, Day</i> , Year)  SEP 0 7 2010	3. Règistrar's Signa	ature de	Red					
DHMH 17 Rev 1/200	1	2		ORIGIN						OCME

Hattie Conwell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			partment of Health and Mertificate of Death	ental Hygiene Reg. No. 2010	27753
		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physic Med		Hattie C. Conwell		Aug 24, 2010	2:09PM
Exam	iner		4b. City, Town, or Location of Death	4c. County of Deat	th '
Funera	1	2324 Druid Park Drive  [5. Social Security Number	Baltimore    If Under 1 Year   If Under 24 Hrs.	8. Date of Birth 9. Bir	thplace (State or Foreign
Directo		217-24-2815 1 M 2 💯 80 Yrs.	Months Days Hours Min.		<sup>untry)</sup> rqinia
ld low	٦.	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	ocation		10d. Inside City Limits
arylan a-f sh fied a	Funeral Director	MD N/A			1 □XYes 2 □ No
the M. or 28 e noti	قَ	10e. Street and Number	Baltimore 10f. Zip Code	10g. Citizen of What Co	ountry?
s 23a nust b	era	2324 Druid Park Drive	21215	U.S.A.	
death item	교	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.) 14. Race - Ame Black, White	
after al", ol	d by	1 Never Married 2 Married 1 Yes No If Yes, Give 1 Year or Dates.	1 ☐ Yes 2 🔼 No Specify:	Specify: Bla	
be filed within 72 hours after death with the Maryland ental Hygiene.  Red other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed	15. Cecedent's Education 16a. Cec	redent's Usual Occupation	16b. Kind of Business	
Pin 72 ne. han "	l E	(Specify only highest grade completed) (Gh Elementary/Seconday (0-12) College (1-4 or 5+)	re kind of work done during most of workin DO NOT use retired)		
d with dygier ther t	BeC		ecretary/Book Ke	eper Conwell (First, Middle, Maiden Surname)	& Sons
be file antal H ked o c eve	P	Jacob Colbert	Helen Co	, , , , , , , , , , , , , , , , , , , ,	
VICE YICE TO SENTE THE SENTE OF			iling Address (Street and Number or Rural		o Code)
le 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	1	Andrew Conwell(son) 22	76 Park Hill Ave	.,Baltimore,MD	21211
Toffer of the state of the sta		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Dis	position (Name of Diematory or other place)	ate 20c. Location - City or	Town, State
t. Pag tmen tmen rtant:			ematery of other place)/H ematery 09/0		
Departing Depart		21. Signature of Funeral Service Licensee	<sup>2</sup> Josephom: Förown 2140 N Fulton Ave	Jr. Funeral Ho e.,Baltimore,MD	ome PA 0 21217
		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
* Physician Medica		Immediate Cause (Final disease or condition resulting in death)	GOCARDIAL IN	PARCT	Onset and Death
Examine	•	Due to (or as a consequence of):	ADRTIC ST	TENOSIS	zears
	ne.	Cequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):			_0
cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c.			
hat the death certificate be executed ed by the attending physician and detached for use as the burial-transit	温田田	resulting in death) Last Due to (or as a consequence of):			
cate b	Physician/Medical	d			
Sertification of the series of	N/CI	IF FEMALE: 23c. Was decedent pregnant   23c. If yes, outcome of pregnancy   1	□ <b>5</b>	23d. Date of del	livery
death ne atte ed for	sicis	in the past 12 months?  1   Ves 2   No	Other (specify)	Month	Day Year
at the	Phy	g ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
signe d be d	d by	HUDEDTELLSIAM		1 ☐ Yes 2 🛣 No 3 ☐ P	
v requires the special	lete	RHEUMATOID ARTHR	TIS	24a. Was an 24b. Were au	topsy findings available
	Completed	7,41		performed? death?	completion of cause of
hysician; The la his certificate ha I director, page 2	BeC	25. Was case referred to medical	26. Place of Death (Check		, 20110
Physic this co	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat  27. Manner of Death 28a. Date of injury 28b. Time		ne 5 Residence 6 Other (Spec	ify)
ding I th. After funer	cate	1) Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation		8d. Describe how injury occurred	
I or Attendin a after death. I Director: Aft d in by the fur	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		8f. Location (Street and Number or Rui	ral Route Number,
pital or At burs after of eral Direct filled in by		building, etc. (Specify)		City or Town, State)	
To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: All completed filled in by the fu	Medical	29a. Certifier (Check (Check only one) (Check one) (Check only one) (Check one) (Ch	estigation, in my opinion, death occurred at t	the time, date and place, and due to the	cause(s) and manner stated.
To the To the comp	2	29b. Signature and little of certifier	29c. License number	29d. Date signed (Month	n, Day, Year)
		1 / Myramun Change	2001546	2 9/3/20	010
X		30. Name and address of person who completed cause of death (Item 23a) (Type MIGUEL KARACUSCHANSKY M.	Print) 200 & 33rd 50	2 9/3/26 +#640 BACTO.	MD. 21218
St	ate	31 Date filed (Modth: Day Year) 32 Ametrar's Signature	2. 41		
Regist					

DHMH 17 Rev 7/2009

10-06615 Da'Quan Carter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 27754 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Medical Examiner Month Day September 2, 2010 0434 hrs DaQuan Jermaine Carter 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Director Months Days Hours Foreign 216-35-9024 1 X M 2 F Country) 18 03/29/1992 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once, 1 X Yes 2 No N/A Baltimore death with the Maryland 10e. Street and Number 10g. Citizen of What Country 喜 3921 Ridgewood Ave. 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married White, etc. 1 Yes 3 Widowed 4 Divorced If Yes, Give Year Pages 1 and 2 should be filed within 72 hours afte rent of Health and Mental Hygene.

ant: If item 27 is marked other than "natural", ir other traumatic event, the Medical Examiner 1 Yes 2 No specify: Specify: Black چ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th Grade Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Herbert Carter Timeka Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timeka Brown(mother) 3921 Ridgewood Ave., Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Josepho Brown F/H And Crematory 09/10/10 Baltimore, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22 Josephes H. Brown Jr. Funeral Home PA 2140 N Fulton Ave., Baltimore, MD 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Asthma Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transi The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 23a,27,per ME g908 10/4/10 TT Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 No 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 XNatural hours after death. 5 Pending the f 1 Yes 2 No \_\_\_ Accident 2 Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) within 24 hours a determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. orbelle September 2, 2010 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

OCME

SEP 0 7 2010

**ORIGINAL** 

aska

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cheryl Lee Cummins Рм September 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center For Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Days 09/15/1944 Mary land Director 213 42 4225 65 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√√ No Maryland Baltimore Essex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 National Drive 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 - Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tormollan Doris (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1554 Jarrettsville Road Jarrettsville, Md 21084 Kimberly Lynn Wunder 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place)

Dulaney Valley Mem. Gardens 9/9/2010 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Si m ure of Funeral Service Licer 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 old eastern Avenue Essex Maryland 21221 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate cause (Final disease or condition Onset and Death Physician/ Small moun Medical resulting in death) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Due to (or se a concequence of): Examin Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant 9 Unknown Pregnant at time of death Dav Year ed by the a detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been sign e 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate ha irector, page 2 performed' death? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 🗌 Yes 2 XINo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 😿 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending nours after death.

neral Director: Aft
dilled in by the fur 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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MARINES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Jennie Marie Cunningham 21:30pM 8/28/2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Med Cen Bel Air Harford 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Hours 036-18-7992 371471925 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County irector 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Harford Bel Air 1 Yes 2 No ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 Funeral 1514 Windwood Rd USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 XXo Specify: Specify Completed 3 KWidowed 4 Divorced white the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done duning most of working life, DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Ith and Mental Hygien
27 is marked other the Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Angelo Cerullo Antonetta Morelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Jo-Ann Harrington / Daughter 1514 Windwood Rd, Bel Air MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date netery, crematory or other place, I Veterans Cemetery 1 🗆 Burial 2 🗆 Cremation 3 Removal from State 9/3/10 4 Donation 5 Other (Specify) Exeter, Victor P. Doda 22 Name and Address of Facility Charles L. Stevens Funeral Home, 1501 East Fort Avenue Baltimore 21. Signature of Funeral Service Licensee Ma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner · onawa Sequentially list conditions, Examine it any leading to it medicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year 4 Pregnant 9 Unknown Pregnant at time of death signed by the a 1 L Yes : P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an cate has page 2 s perform After this certificate 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred atural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 060768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPPER Chesapeake D., Muhammad 31. Date filed (Month, Day, Year,

Registrar

State

ms00387763

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Victorine Camara 15;42 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Conter University of Maryland Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 1 Month Day. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 51 Guinea **Director** Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Experiment and be rectified at X□Yes 2□No Director **Baltimore** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 2200 Green Street Funeral Guinea 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married Maryland 21215-0036 Black 1 □Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 172 h 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Firm Accountant 12th grade alth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Suzane Bangoura 2 Adolph Camara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traunonce. 2200 Green Street, Baltimore, Maryland <u> Abdoul Toure-Husband</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Family Plot 9/10/2010 Conakry, Guinea 22. Name and Address of Facility
Bergen Funeral Home 21. Signature of Funeral Service Licensee <u>232 Kipp Ave, Hasbrouch High,</u> NJ 07604 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final endocarditis **Physician** Iricuspid valve disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner coronary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). The law requires that the death certificate be executed Ventricular Fibrillation resulting in death) Last Due to (or as a consequence of): burialphysician at the burial Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) signed by the a I be detached for P.0. 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Type 2 Diabetis Mellitus Hypertension Brain anoxia 1 Yes 2 No 3 Probably 4 Unknown vascular Peripheral disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed cate 2 No 1 □Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ( Medical Certification: To After th funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Soptember 3 2010 100568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St. Baltimore, MD 21201 atrick Bering 22 MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per FH G907 9/09/10 Jh State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret P. Calhoun 31, 2010 August 9:50 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Heart Homes of Lutherville Lutherville 8. Date of Birth (Month, Day, **April** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Day Year, 1919 Wilmington, DE. 91 Months Days Hours 220-03-4002 Director Usual Residence of Decedent show 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits PA. 1 Yes 2 No York County Shrewsbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 253 Prospect Circle 17361 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black. White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 Nidowed 4 □ Divorced White "natural", Specify: Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Dixon Pitts Margaret Purnell 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret Connelly Young 253 Prospect Circle Shrewsbury, PA. 17361 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Paul's Episcopal Ch. Cent. Berlin, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Leffrey L. Gair, Sr. 22. Name and Address of Facility

Reaceful Alternatives Funeral & Cremetion Center, P.A. My L(Lic. #M00677) 2325 York Road Timonium, Maryland 23a. Fay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical b. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 1 ☐ res ∠ ₩ ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P. Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been sit completed filled in by the funeral director, page 2 should t 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 🗷 25. Was case referred to medical Be 26. Place of Death (Check only one) 45istedte Other: 4 Nursing Home 5 Residence 6 Other (Special Hospital: 1 ☐ Yes 2 ☑ No မ ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Balto and 20204 GBMC (0 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month : 45 PM Physician/ Medical County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmine Baltinare 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Country) GERMANY Funeral 1 🗆 M 2 🖫 F Months Hours 0971777923 86 212-20-5584 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21208 8911 REISTERSTOWN ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Je filed with... ∼tal Hygiene. ∽or than "r (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) COSMETOLOGY should be filed with and Mental Hygien is marked other th HAIRDRESSER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ BENDER IRMA PRAGER NATHAN other traumatic permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3004 HERNWOOD ROAD, WOODSTOCK, MD AUSTIN COHEN/SON 20b. Rlapp of Disposition (Name of Carboten) elements of other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ò 09/01/2010 RANDALLSTOWN, MD CHESED CEMETERY 4 Donation 5 Other (Specify) injury 22. Name and Address of Facility of Funeral Service Lice SOL LEVINSON & BROS., any in 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and the for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown detached P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? page 2 should be de ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Certificate: To Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed Yes 2 1 Yes 26. Place of Death (Check only one) **Division of Vital** the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Other: 105 2 2 40 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at s after death. 27. Manner of Death 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending M 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29c. Liçense number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2010

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed

31. Date filed (Month, Day, Year)

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se of death (Item 23a) (Type, Print)

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P.O. Box 68760	
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Baltimore,	permit, Page 1 a Department of F Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other  21. Signature of Fundal Service		GA		FOREST		08-10		LS, MARYLAND			
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Box 68760	Attending Physician: The law requires that the death certificate be ar death.  Frideath and the actor. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE:	23c, If yes, outcor	no of proons	IDCV								
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Division of Vital Records,	been should	Completed by							24a. Was a	an 24b. Were a	utopsy findings available			
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isio	Atten er dear ector; by the	ertifi	3 Suicide 6 Cou	ld not be 28e. Place of	Injury - At ho	ome, farm, stre	eet, factory, office			Street and Number or Ru	ural Route Number,			
<u>S</u>	Hospital or 24 hours afte Funeral Din sted filled in				etc. (Specify				City or Tow					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	Medical	(Check 2 Medica	ng Physician: To the best I Examiner: On the basis on Ing Nurse Practioner: To the	f examinatio	n and/or invest	tigation, in my opini	on, death occurred	at the time, date a	nd place, and due to the	cause(s) and manner stated.			
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/			30. Name and address of person	SUSAI M.B.	RIG	CINE	Al HOSP	ITAL OF	BALT	IMORE				
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3	Physici /Medic		1. Decedent's Name (First, Middle, Last)	JIBS				2. Date of Dear	Day 31	*2011	3. Time of Death  9/10 PM
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iu .	Funeral Director		5. Social Security Number 6. Sex 214-62-5779 XC M	7. Age (In yrs. 57		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 07/04/	Year)	Count	ace (State or Foreign try) /land
	ryland show		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo					10	Od. Inside City Limits  12 Yes 2 No
	Ba-f	ecto	MD N/A		G'	wynn Oal	ζ		0g. Citizen of \	Mhat Coup	
	with ti	Funeral Director	10e. Street and Number 2902 Bowers Ave.			10f. Zip Code 21207	7		U.S.		uy:
	death ma 23	nera	11 Marital Status 12. V	Vas Decedent Ever in U	I.S. 13.	Was Decedent of H	ispanic Origin? (Spon, Mexican, Puerto	ecify Yes or No-	14. Rac	ce - America	
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/lar	ould be filed with Mental Hygiene. arked other ther atic event, the	To B	Moses Daniels Sr.		,		Susan Le	emon			
Maryland			19a. Informant's Name/Relationship (Type,	,		•	and Number or Rura				
	s 1 and 2 should f Health and Mer Item 27 is marke othar traumatic		Moses Daniels Jr.  20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of		oate Co	1 UMD 1 a 20c. Location		
Baltimore,	Page nent o int: If		1  Burial 2  □ Cremation 3  □ Remo 4  □ Donation 5  □ Other (Specify)  21. Signature of Funeral Service Licensee	val from State	ing M	em. Parl	k 09/0	_	Baltin		
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Carlos Carlos	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one of Immediate Cause (Final disease or condition fesulting in death)	ause on each line.	th. Do not ent		g, such as cardiac	· ·			Approximate Interval Between Onset and Death
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	kecuted and I-transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	DIASEM		MUN	>				
8760,	cate be executed obysician and the burial-transit	dical Ex	d	Due to (or as a consec	quence or).						
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	quires that the de n signed by the a uld be detached f	Ď	Part II. Other significant conditions contrib CHRONIC LIVEYZ	uting to death but not res	sulting in the u	ndarlying cause giv	en in Part I. HtpC)		bacco use con es 2□No	tribute to th	ne cause of death?
Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed	THEOMISOCOPOPE	A UE				24a. Was autop	med?	Were autoprior to condeath?	psy findings available mpletion of cause of
/ita	Physician: rthis certifica ral director, i	Be	25. Was case referred to medical examiner?	itali		04	26. Place of Deat	h (Check only or	ne)		The sale
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lon	ding th: After	tlon	1	8a. Date of Injury (Month, Day Year)	Injury	Wor	Yes 2 No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division of	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification;	a Could not be	8e. Place of Injury - At h building, etc. (Speci	nome, farm, sti ify)	reet, factory, office		28f. Location (S City or Tow		ber or Rura	l Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical (	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:								
	To the To the Complex	Σ	29b. Signature and title of certifier			29c. Licens	e number 02878	51	29d. Date signe	31/1	Pay, Year)
7			30. Name and address of person who compl	eted cause of death (Ite	23a) (Type,		H, HAG	eastown	UM C	)	
	Sta		31. Date filed (Month, Day, Year)	32. Postrar's Sign	ature						
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 24 2010 6:45 Ам Elizabeth McAllister Delea Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Hours 219-34-1448 73 Days June 7 ay, Y Director Maryland Usual Residence of Decedent Department of Health and Mental Hygiene Important, or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland | Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 900 Greenleigh Rd. 21212 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) hospital nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be Richard Alexander McAllister Ciril Catherine McAllister Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael F. Delea III/son 6 Nathaniel Ct. Glen Mills, PA 19342 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Maria Cemetery Sep. 8,2010 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home,
6500 York Rd. Baltimore, MD 2 ignature of Funeral 23a. Part 1. Enter the disease, or comp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, hadring to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မြ 1  $\square$  Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 A Natural 2 Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Xertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar OHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death 8. Date of Birth Sept. 28 **Funeral**  Birthplace (State or Foreign Country) 1 X M 2 D F Months **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 XCYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? p 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 💢 No 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Part 1. Enter the disease, o complications that caused shock, or heart failure. List only one cause on each line. disease, of complications that caused the death. Do not enter the mode of glying, such as cardiac or respiratory arrest, Approximate terval Betev Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a dop sequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence The law requires that the death certificate be executed Cause (Disease or linjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 No Yes 2 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Natural injury work? 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certific icense number 29d. Date sign eath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of ^Ce 31. Date filed (Month, Day, Yea State 7 2010 Registrar

			Please 1 - <sup>For</sup> State Registrar	State of M	<b>nt in l</b> arylan	d / Depa	<b>idelible In</b> artment of I <i>tificate of l</i>	Health and N	Mental Hy	s Are giene Reg. No	2010	27764
	Physicia Medic		Decedent's Name (First, Middle, La		el M.	Drumm	Jr.		2. Date of Dea Month Sept.		<sup>ay</sup> 2010	3. Time of Death 2:15 A M
	Examin		4a. Facility Name (if not institution, giv Stella Maris Ho	,				r Location of Death Onium				ore Co.
-	Funeral Director			Sex 7. Ag	e (In yrs. la	as <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt OCt 2	th y, Year)	9. Birth	place (State or Foreign
	ryland -f show ied at	ctor	Usual Residence of Decedent  10a. State 10b. County	-	10c. City	y, Town or Loc	cation					10d. Inside City Limits
	th the Ma 3a or 28a t be notif	<b>Funeral Director</b>	MD Balti	imore			10f. Zip Code		emere	_	itizen of What Cou	
036	e filed within 72 hours after death with the Maryland tral Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		7710 Dory Lane  11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent I Armed Forces? 1  Yes 2  If Yes, Give Year or Dates.		H	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)		United St 14. Race - Americ Black, White, Specify:	can Indian,
15-0	72 hour In "natu Medical	Completed by	15. Decedent's I (Specify only highest g	Education rade completed)		(Give H	lent's Usual Occup kind of work done of NOT use retired)	during most of work	ing	16b. K	Kind of Business In	dustry
212	d within ygiene. her tha ht, the I	Be Co	Elementary/Seconday (0-12) 9 Years	College (1-4 or s	ó+)		el Worke	r			Steel Inc	lustry
land	should be filed with h and Mental Hygien 7 is marked other ti traumatic event, the	To B	17. Father's Name (First, Middle, Last) Samuel M. Di					18. Mother's Nam Ca			Surname) nantchas	
, Mary	of Health and Ments of Health and Ments fitem 27 is marked r other traumatic e		19a. Informant's Name/Relationship ( Samuel M. Drumm,		)	19b. Mailin	g Address (Street Bulls L	and Number or Rura ane Jopp	al Route Number a, Mary	r, City oi 1an c	r Town, State, Zip of 21085	Code)
Baltimore, Maryland 21215-0036	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ 4 ☐ Donation 5 ☐ 9ther (Spee		C	emetery, crem	sition (Name of natory or other place Service	ce) 9/7	Date /2010		ocation - City or To	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Ligen	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		22	PDDAPEBBBC	e Fulleral	Home of	f Du	ındalk, I	nc. 1222
			23a. Fart 1. Etter the diseas , or con shock, or neart rilure. List only Immediate Cause (Final	nplications that caused one cause on each line	the death			g, such as cardiac o			yrand Z	Approximate Interval Between Onset and Death
	Physician/ Medical Examiner		disease or condition resulting in death)	a. CEREBRO  Due to (or as			CCIDENT			_		Shock and Boath
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury that initiated events	b. Due to (or as	a consequ	ence of):						
	be e; siciar buris	g	resulting in death) Last	Due to (or as	a consequ	ence of):						
. Box 6876(	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	Ideath 3 🗌	Ectopic pregnand Other (specify)	ey .			23d. Date of deliv Month	ery Day Year
Division of Vital Records, P.O.	uires that th in signed by uld be deta	þ	Part II. Other significant conditions of	contributing to death b	ut not resu	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did to			ne cause of death?
Recor	The law rec ate has bee bage 2 sho	Completed									prior to co death?	psy findings available mpletion of cause of
ta	ician: certifica ector, l	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death (Check	only one)			
of V	y Phys er this eral dir	e:	1 ☐ Yes 2 🗶 No 27. Manner of Death	1 ☐ Inpation	ry	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injury	4 L Nursing Ho	me 5 Resid			HOSPICE
ion	tending leath. or: Afte the fun	Certificate:	1 X Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b		, Year)	injury	work	? Yes 2□No				
Divis	inital or Aturs after or ral Direct		4  Homicide determined	building, etc	(Specify)				City or Town	n, State)		
	he Hosp iin 24 ho he Fune ipleted fi	Medical	(Check 2 Medical Exam	vsician: To the best of niner: On the basis of ex rse Practioner: To the	kamination	and/or investi	gation, in my opinio	n, death occurred at	the time, date ar	nd place	, and due to the car	use(s) and manner stated.
	Vith To t		29b. Signature and title of certifier	SCINI	0		29c. License	number 19792		29d. Dat	te signed (Month, 1973) ZVI	
	らく		30. Name and diddless of berson who				LEY RD	THE STATE OF THE S	( )() 0:	000	,	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	Signat	arke	HET KIJ.	TIMONTUM	1, MU 21	.093		

SEPTEMBER 3, 2010 2:15 a.m.

SAMUEL DRUMM

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ada V. Diggins 2010 August 28 5:45a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Sykesville Transitions Health Care Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□√F Days Hours Months MD Sept 26 1923 Director 217-18-3899 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show ir items 23a or 28a-f showing the restition of Sykesville 1 ☐ Yes 2 ☐ No MD Carrol1 Director with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 7029 MacBeth Way Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married th and Mental Hygiene.
7 is marked other than "natural", or i traumatic event, Its Medical Evan in Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 🛣 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lorena Williams John Germack ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trainonce. 2314 Pin Oak Dr., Finksburg, MD 21048 Mr. Wayne Diggins (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-2-10 Baltimore, MD Holy Redeemer Cem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Para Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause for injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes → No Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one. and manner stated. 29b. Sign ature and title of ce 30. Name and address of person who completed cause of death (Item 23a) TOUGO State SEP 0 7 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Alice Ellison September 7:00a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sep. 28, 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🕱 F Hours 216-14-2014 **Director** 87 Sep. Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Baltimore Baltimore 10e. Street and Number 10q. Citizen of What Country? Funeral 640 Aldershot Road 21229 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 Midowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Newspaper Reporter/ Editor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland ည Albert Anderson Flora Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 640 Aldershot Road, Baltimore, Maryland 21229 Edward A. Ellison, III, Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 
Burial 2 
Cremation 3 
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/5/2010 Metro Crematory Inc Baltimore Maryland icensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any second ground for cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical LE FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sis completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Tes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work' 1 \sum Yes 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

23001

r's Signature

			1 – State Registrar				Cer	tificat	e of	Death			Reg. No.	UIU	21	101
À	15.0		1. Decedent's Name (First, Midd	fle, Last)		*					2. Date of De	eath		3. Time	e of Death	
1	Physici: /Medic		Virginia	H.		E	Sz					8/	28/20	10	1	220a <sup>M</sup>
	Examin		4a. Facility Name (If not institution Longview Nurs.	ing Home	ımber)					r Location ester	of Death		4c. County of Death  Carroll			
	Funeral Director		5. Social Security Number 282–12–6417	6. Sex 1 ☐ M 2 ☑ ▼	7. Ag	e (In yrs. last birti	hday)_ 'rs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 11/9	rth ay, Yea <i>r)</i>	9. Birtl	nplace (Sta untry) OH	te or Foreign
7	- ^		Usual Residence of Decedent													
200	how	_	10a. State 10b. Count	y Carroll		10c. City, Town										e City Limits  es 2 🔼
W	liffled	cto	MD '			IMa	ncn	este	r 						· Ц т	es ZLINO
d; d;	3a or 28	al Director	10e, Street and Number 3332 Main S	Street				10f. Zip		21102	2		10g. Citizen of What Country?			
100	ms 2	Funeral	11. Marital Status	12. Was Dec	cedent	Ever in U.S.	13. W	Vas Dece	dent of H	lispanic Or	rigin? (Sp	ecify Yes or No Rican, etc.)	0- 14	I. Race - Ame Black, White		),
5-0036	al', or ite	þ	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Voc C	2 1 live Dates:	No		☐ Yes		Specify		rilidan, elely		Specify:	Whit	æ
	natur ical i	ted	15. Decede	nt's Education est grade completed	)	16a.	Decede	ent's Usu	al Occup	ation	st of work	ina	16b. Kind	d of Business/	ndustry	
d 21215	than "	Completed	Elementary/Secondary (0-12)			i+)	life. D	Home	se retired make	during mod d) <b>Y</b>	st or work	ang			Own	Home
		To Be C	17. Father's Name (First, Middle Oris C. Di							18. Moth	er's Name Sadi	e (First, Middle .e Hai	e, Maiden S ught	urname)		
aryla			19a. Informant's Name/Relation	1 1 21	,	<b>I</b>		-				al Route Numi				
	alth a		Dorothy	Whittle	/Da	ughter	84	0 Bu	ckho	rn Ro	pad,	Sykesv:	ille M	D 2178	4	
ore	If iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 MRomoval from	State	20b. Place of cemeter	Dispos y, crem	sition (Nar natory or c	ne of other plac	ce)		Date	20c. Loca	ation - City or	Town, State	9
altimore,	nent ant: I		4 Donation 5 Dother (	Specify)						Parl		9/3/10		cinnati	•	Ŧ
Salt	Department Department almoortant: If any injury or once.		21. Signature of Funeral Service	e Licensee V1Ct	or 1	P. Doda	Çĥ	Name ar	nd Addre S L.	ss of Facil Stev	<sup>ity</sup> ens	Funera , Balt	L Home	Inc.		
20 8	205 20	NO.	, O'CO			>								'MD 21		
-			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that st only one cause on	caused each li	I the death. Do n	ot ente	_ /		_	8. 75	or respiratory	arrest,			mate Between Ind Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	_a U	ny	ester	e	240	min	18	uli	ire			54	la
	/Medical examiner		, <u>.</u>	Dy to	o (or dis	a consequence o	of):	01	1						101	
9		-	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as	a con eque de c	f):	th	74						104	
100	ansit	Examiner	Cause. Litter Underlying Cause (Disease or injury that initiated events	S an	100			-pl	· V	l CLA L	1.11	ulle	n las		20	Lan
J,	in and ial-tr	Exa	resulting in death) Last	Due to	(or as	a consequence o		·			~~~	CLIV-C				1"
68760,	ysicia ye bu	ca		d												
	ding physician and se as the burial-transit	/Medical	IF FEMALE:													
			23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth	pf pregnancy 2 ☐ Fetal death		Ectopic p		y			23	3d. Date of del Month	ivery Day	Year
. 7	0 0	Physiciar	1 ☐ Yes 2 No 9 ☐ Unknown	4⊟Preg 9⊟Unki		t time of death	5 🗆	Other (sp	pe <i>cify)</i> _						54,	
D 5	been signed by the should be detached		Part II. Other significant condi	tions contributing to	death b	ut not resulting in	the un	derivina	ause div	en in Part	I.	23e, Did	tobacco us	e contribute to	the cause	of death?
Records,	signe d be	d by		3		3		, ,				1 🗆	Yes 2	No 3□Pr	obably 4	Unknown
Ö	been	etec										24a. Wa	s an	24b. Were au	itoney findir	nge available
He He	2 38	Completed										auto	opsy formed?	prior to death?	completion	of cause of
Vital	certificate har		25. Was case referred to medic	al						26 Plan	e of Deat	1  Yes th (Check only	- '	1 □ Yes	2 No	
	ysicing is cert	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatie	ent 2 ⊟ ER/Out	patient	3 D	OA Oth	or.		ome 5 Res		□Other (Sne	cify)	
0 4	erthi eral c	n: To	27. Manner of Death	28a. Date	e of Inju	iry 28b. T	ime of		28c. Inju		uroming i ic	28d. Describe			y)	
ion in	ath. r: After e funera	aţio	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ing (Wo. tigation	пет, ра	y rear) "	njury	М		Yes 2	]No					
Division or	after death.	iiic	3 Suicide 6 Could 4 Homicide deter	minod 20t, Flat	ce of inj	ury - At home, far c. (Specify)	m, stre	et, factor	y, office			28f. Location	(Street and own, State)	Number or Ri	ural Route l	Number,
בֿ בֿ	al Dia ed in	Certification:			ug,											
Division	within 24 hours and the Euneral Completely filled	Medical		ing Physician: To that Examiner: On the and ma	basis o	f examination an										se(s)
Ę	within To the comply	Me	29b. Signature and title of certif	ier M.	1	11:4	-	29	c. Licens	se number	44	>	29d. Date	signed (Mont	h, Day, Yea	ar)
			30. Name and address of perso	n who completed cau	use of r	leath (Item 23a)	Type. F		ر د	ــ د ـــ	173		01	2/2	UIU	
			John W.	Middle	eta	M MD	4	88	Pco	k K	2, 1	Vietn	inst	m, v	D	2115/
À	Sta Registi		31. Date filed (Month, Day, Yea	2010	agra.	v B.	ba	stal								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September bay Julia Dolores Farnsworth 4:40 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Perring Parkway Parkville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 M 2 X F Hours (Month, Day, June 29, Days 280 10 5650 Director 94 West Virginia Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Middle River 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 810 Pineview Place 21220 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2X No Specify. White 3 → Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Clerk 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ledrue Ward Essie Frymier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Wayne Farnsworth (Son) 3231 Montebello Terrace Baltimore, Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Bayview Crematory Inc. 9/7/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) any in 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA DIR Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical MD Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Month Day Year Pregnant at time of death After this certificate has been signed by the functional director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown ECUBITUS ULCERS. 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🛚 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 10069 person who completed cause of death (Item 23a) (Type, Print) QUIAN ST. BARTIMORE 21201, MD State 32. Registrar's Signature

Registrar
DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Vilbur Farver,	Jr	1- For State	tate of Marylan		artment o <i>rtificate o</i>		d Mental I		201	0 27769		
Physic	ian/	Registrar  1. Decedent's Name (First, Midd	lle,Last)				-	2. Date of Dea	eg. No.	3. Time of Death		
Medical Exam			an Farver	Jr.				Month August 28	Day Year 3, 2010	0656 hrs		
		4a. Facility Name (if not institution				4b. City, Town, or	Location of Dea		4c. County of D	eath		
		Route 340				Brunswick			Frederick			
Funera		Social Security Number		Age (In yrs. I	last birthday)	If Under 1 Yea  Months Day			rth(MM/DD/YYYY) 9			
Director		215-74-7730	1XM 2 F		53 Yrs		S Hours IVI		15, 1957	preigi <b>Pennsylvania</b> Country)		
any		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Locat	ion				I dod to ide Citationia		
<b>*</b> .			2.2	Toc. City	, TOWIT OF LOCAL		•			10d. Inside City Limits  1 XYes 2 No		
Maryland 28a-f show 1 at once.	햙	Maryland Ca	arroll			Union 10f. Zip Code	Bridge	I a	On Citing of Market			
th the Maryland 23a or 28a-f sho notified at once.	Director		- 05			101. Zip Code		1'	0g. Citizen of What (			
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	<u>a</u>	201 E. Elgei	12. Was Decede	ent Ever in II	S T13 W/s	s Decedent of His	21791	Enocify Voc or No		J.S.A. nerican Indian, Black,		
eath v item: ust be	Funeral	1 Never Married 2 X M	arried Armed Force	es?		es, specify Cuban			White, et			
fter d ", or		3 Widowed 4 Div	orced If Yes, Give Year 1 or Dates:	<sup>2</sup> <sub>No</sub> 975-83	3	Yes 2X No	specify:		Specify:	White		
ours a atura (amin	d by	15. Decedent's Education (Spe	cify only highest grade of	completed)	16a. Deceder	t's Usual Occupat	tion (Give kind of		16b. Kind of Busine			
27 -	lete	Elementary/Secondary (0-12)	College (1-4	or 5+)	during m	ost of working life.	. DO NOT use re	tired)				
5-0036 led within 72 hours Hygiene. t other than "natur the Medical Exam	Completed	12			tract	or trail	er drive	er	transpor	rtation		
15-C		17. Father's Name (First, Middle	•						Maiden Surname)			
21215-0036 hould be filed within 7 ind Mental Hygiene, is marked other than tite event, the Medica	o Be	Wilbur I. Far 19a. Informant's Name/Relations	ver, Sr.		T		Melvi	na Sarah	Raffensbensber, City or Town, S	erger		
O & B is ig	ľ											
ore, ME es 1 and 2 sl of Health ar If item 27		Antoinette Fary 20a. Method of Disposition	er/ wrie	20b. F	Place of Dispos	<ul> <li>Elger</li> <li>ition (Name of cen</li> </ul>	netery.	nion Bri	dge, MD 2	or Town State		
iges 1 it of F r. If i	١.	1 Burial 2 X Cremation		State	crematory or otl	ner place)		104 100 40		,		
Baltimore, MD oermit. Pages 1 and 2 sho Department of Health and Important: If item 27 is niyory or other traumati		4 Donation 5 Other Si 21 ature of Funeral Service	pecify:	I AL.	1 Count	y Cremat	$10n \mid 8$	/31/2010	Sykesv	lle, MD		
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum:		athanie (	Xan er	/	6	E. Broad	Way Hai	rtzler F	uneral Hor idge, MD 2	ne 01701		
Physician		23a. Part I. Enter the disease, or	complication at cause	ed the death.				or respiratory arre	est, shock, or heart	Approximate Interval		
/Medical		failure. List only one cause Immediate Cause (Final disease		∋s						Between Onset and Death		
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si, d	xan	events resulting in death) Last	Due to (or as a cor	nsequence of	f):							
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O, e be e ysician burial	edical	UNPENDED	AMENDED									
Box 6876C death certificate the attending physic for use as the bh	ian/Me	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outo	come of pregr	_	al death 3	Ectopic pregn	ancv	23d. Date of deliver Month	very Day Year		
X 6 th cert trendii	ပ	past 12 months?	4 Pregnant	at time of dea		ner (Specify)		,	1	July 10ai		
Boy ne death the att	Physi		9 Unknown									
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. The this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	b.	Part II. Other significant conditi	ions contributing to de	ath but not re	esulting in the u	nderlying cause gi	iven in Part I.			to the cause of death?		
duires					-							
cords, law requir has been s	be				<del>-</del>			24a. Was a autops	sy prior	autopsy findings available to completion of cause of		
Rec The licate	Completed							perform 1 ✓ Yes 2				
Vital Reovision: The his certificate director, page	Be (	25. Was case referred to medical examiner?	Hospital:				of Death (Check					
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n of Iding P. h. : After e funera	Ë	1 Natural 5 Pend	Aug (Month, Day	(Year)	0640 hrs	· ·   _ · ·	y at Work? es 2 ✔ No		ow injury occurred auto collision			
Sional Atter	cat	2 🗸 Accident Inves	tigation	Injuny - At ho	me farm stree	t, factory, office bu		20f Langtian (C	Annah mad Nijambar as	Rural Route Number, City		
Division spital or Attendii ours after death. teral Director: A	Certification:	deter	not be		l / Highway	i, ractory, office be	aliding, etc.	or Town, St				
Hospi 4 hou Funer ely fil		22 2 15	ysician: To the best of			ed at the time dat	te and place, and			<u> </u>		
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the t	Medical		niner:On the basis of ex and manner stated	amination an								
F 3 F 3	Ne S	29b. Signature and title of certifie		d		29c. License	number		29d. Date signed (/	Month, Day, Year)		
		Maranio A	e Vrill			O.C.N	M.E.		August 29, 201	0		
P.,	ı	30. Name and ddress of person				-						
1 V		Margarita Korell MD.	Assistant Medica			nn Street, Ba	Iltimore, MD	21201				
St Regis		31. Date filed (Month, Day, Year)		ar's Signatur	bar	Kel						

			Amend 19b, per	Type or Pri Fn G907 9 State of Ma	<b>1, in</b> 1 130/ arylan	<b>Black I</b> 10 TT id / Dep	<b>ndelik</b> artme	ole Inle	<b>k. Ens</b> lealth	ure A and N	<b>III Copie</b> Mental Hy	s Ar	e Legib	le. ∩	27770	1
		_	State     Registrar			Ce	rtifica	te of L	Death			Reg. N	201	U	27770	-
	Physicia	n/	1. Decedent's Name (First, Middle, Las	t)							2. Date of De Month		ay Ye	ar	3. Time of Death	
	Medic		Sophie Abrams		r						Septem	ber	03, 20	010	12:00 P M	
	Examin	er	4a. Facility Name (if not institution, give	street and number)			4b. City	, Town, or	Location (	of Death		4	c. County of D	eath		
			Collingswood Nurs: 5. Social Security Number 6. Se			Cente ast birthday)		ockvi er 1 Year	111e I If Under	24 Hrs	8. Date of Bir	th		ontgomery  9. Birthplace (State or Foreign		
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*			Usual Residence of Decedent		0	8 115.       03/19/192									VA	_
	shov dat	tor	10a. State 10b. County	10c. Cit	Oc. City, Town or Location								10	d. Inside City Limits		
	Mary 28a-f otifie	Director	MD Montgom	ery			Roc	kvi1	1e						1  Yes 2 □ No	
	To the street and Number 10f. Zip Code 10g. Ci									itizen of What	Count	ry?				
	h with	299 Hurley Ave.  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-									USA	Α				
	deat r iten iner r		11. Marital Status	<ol><li>Was Decedent E Armed Forces?</li></ol>		S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, W			
36	after al", o xam	d by	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗶	No		1 🗆 Yes	2 <b>X</b> No	Specify:				Specify:		1	
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pu	filed all Hy doth	o Be	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	e (First, Middle,	Maider	Surname)			
Maryland 21215-0036	Top   Top															
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Baltimore,	nt of ht of t: If it		1 🗶 Burial 2 🗆 Cremation 3 🗆		0	emetery, cre	matory or	other plac	· .		Date		_ocation - City			
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Ba	permi Depar Impor any ir	8 9	21. Signature of 1 uneral Service Licens	full	More	F	dward	Sag	el Fu	nera	1 Direc	cțio	n Inc.	005	2	į
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	Physician	23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   No cardial Infarction  Due to (or as a consequence of):													Interval Between Onset and Death	
	Medical														Months	-
Same	Examiner			Coronai			Disea	se						У	ears	
		Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a												
B	executed an and rial-transit	xam	Cause (Disease or iinjury that initiated events	c. Atheros			Heart	Dis	ease					$\bot$		_
1			resulting in death) Last	Due to (or as a	consequ	uence ot):										
Box 68760	cate be e physicia s the buri	by Physician/Medica		d										+		_
687	ath certifica attending p	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	incy							23d. Date of	dallua		
ŏ	atten atten for u	ciar	in the past 12 months?  1  Yes 2  No	1 ☐ Live Birth 4 ☐ Pregnant at			☐ Ectopic ☐ Other (s		У				Month		y Day Year	
. B	requires that the de been signed by the should be detached	hysi	g Unknown	9 🗌 Unknown												
P.O.	that I	y P	Part II. Other significant conditions co	ontributing to death b	ut not res	ulting in the	underlying	cause giv	en in Part	I.	23e. Did t	obacco	use contribut	e to the	cause of death?	
ds,	quires en sig uld b	pa	Degenerative	y Joint Di	seas	e					1 🗆	Yes 2	<b>X</b> No 3 □	Prob	ably 4 🗆 Unknown	
Ö	w rec is bee 2 sho	Completed	Chronic Lung	Disease							24a. Was		24b. Were	autop	sy findings available apletion of cause of	
3ec	The law ate has bage 2	you									perfe	ormed?	deatl	1?	2 🗌 No	
<u></u>	ian: ertifica ctor, p	Be (	25. Was case referred to medical examiner?					26. Pla	ace of Dea	th (Check						
Ξ	<b>Physician:</b> The lar this certificate ha ral director, page 2	10	1 ☐ Yes 2X No			ER/Outpatie		Othe	er: 4X Nu	ırsing Ho	me 5 🗆 Resi	dence	6 🗌 Other (S	pecify)		
י סל	ing P	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injui (Month, Day	y Yea <i>r</i> )	28b. Time o injury		28c. Injury work	?	- 1	28d. Describe I	now inju	ry occurred			
joi	ttend death tor: /	tific	2 Accident Investigation 3 Suicide 6 Could not be		^		M		Yes 2		2001	<u> </u>		2 11		_
Division of Vital Records,	lor A after Direc	Cer	4  Homicide determined	28e. Place of Inju building, etc			reet, lactor	y, onice		- 1	28f. Location ( City or Tov			Hurai i	toute Number,	
	spita hours neral 1 filled	ical	29a. Certifier 1 Certifying Phys	ician: To the best of	ny knowl	ledge, death	occured a	t the time,	date and	place, an	d due to the ca	ause(s) a	ınd manner as	stated		
	To the Hospital or Attending Physician: The law requires that the death certificate be within E4 mours after death certificate be within E4 mours after death. To the Lameral Director: After this certificate has been signed by the attending physici to the theratal Director. After this completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Medical	(Check 2 Medical Exami	ner: On the basis of ex Practioner To the	amination	n and/or inve	stigation, in	my opinio	on, death or	ccurred at	the time, date	and plac	e, and due to t	he caus	se(s) and manner stated	d.
_	North Com		29b. Signature and title of gertifier	0 ,			29	c. License	number	3		29d. Da	ate signed (Mo	onth, D	ay, Year)	
			1	Le				219	60	7		Se	ptembe	r 4	2010	
	10		30. Name and address of person who c				,									
	Stat		Raman R. Tuli M. 31. Date_filed_(Month, Day, Year)	D. 10810 32. Registra	Dar	nes To	own Re	oad S	uite	202	. Gaith	erst	ourg. M	ID 2	0878	į.
	Registra	184	SEP 0 7 2010			bank										

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death	10 27771
Physic /Medi			Year 2010 3. Time of Death
Exami		14a. Facility Name (If not institution, give street and number) 44b. City, Town, or Location of Death 4c. Co	Baltimore
Funeral Director		5. Social Security Number  213-34-7806  Usual Residence of Decedent  6. Sex  1	9. Birthplace (State or Foreign Country)  Spain
the Maryland 28a-f show	tor	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
h with the 23a or 28s	al Director	10e. Street and Number 10f. Zip Code 10g. Citizer 302 Crisfield Court 21009	of What Country?
DESIGNATION FOR INTERPLIANCE ALLES-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event and control once.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Narried 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Race - American Indian, Black, White, etc.
Z1Z13-UU36 d within 72 hours ali glene or than "natural; or the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Supervisor  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Supervisor	of Business/Industry
Maryland Z id 2 should be filed the and Mental Hygie 27 Is marked other traumatic avant, I	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Su.	тате)
and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or To  Marci Kotula - Niece  302 Crisfield Court Abingdon, Maryland 210	
Saltimore, semit. Pages 1 ar Department of Hea mportant: If item nny injury or otha		1 XBurial 2 Cremation 3 Removal from State Gardens of Faith Cem.  1 Donation 5 Other (Specify)  1 XBurial 2 Cremation 3 Removal from State Gardens of Faith Cem.  1 XBurial 2 Cremation 3 Removal from State Gardens of Faith Cem.	ion - City or Town, State nore, Maryland
Departing any in poor		21. Signature Fibraral Service 1970 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Leonard J. Ruck, Inc. Baltimore, MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line.	
Physician / Medical Examiner bubblished state pricarial transit state pricarial transit state of the pricarial transit state	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tany loading to in neclistic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Onset and Death
e death certii	Physician/Medi	0	. Date of delivery Month Day Year
w requires that the been signed by should be detach	þ	Part II. Other significant continuous continuous go to dearn but not resoluting in the uncertying cause given in Part I.	contribute to the cause of death?
sician: The law requires to certificate has been signe lirector, page 2 should be to	Completed	24a. Was an autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Phy Phy P	ation: To Be	examiner?  1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Mursing Home 5   Residence 6	
To the Hospital or Attanding within 24 hours after death of the Funaral Director: After completely filled in by the fune	Certification:		umber or Rural Route Number,
the Hosi hin 24 ho tha Fune npletely f	Medical	29a. Certifier (Check only once) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and concern death occurred at the time, date and place and place and manner stated.	ce, and due to the cause(s)
with To con	4	Bet. M.D. 069540 8	gned (Month, Day, Year) 30 2010
3v		24 Det Class (14 at 0 at 14 at	kn'lle MD 2123
Sta Registr	-	ar 31. Set 10 (Menth Day Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Ferguson 8:35 AM Augustus 08 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore NA Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🙀 M 2 🗆 F 218-42-8097 Director 64 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD NA 1X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3142 Leeds Street 21229 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. African ð 1 Never Married 2 K Married Yes 2XXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: American permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once." 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade NA Mechanic Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ferguson Flossie Chambers 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 William C. Ferguson 3142 Leeds Street Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09-08-10 Woodlawn Cem. Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wylie Funeral Home 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Sepsic Physician/ disease or condition resulting in death) week Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by heel gangrene, End stage renal disease on 1 Yes 2 No 3 Probably 4 Unknown hemodialysis, peripheral vascular disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Chronic Anemia secondary to end stage renal disease 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ပု 1 Xinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Matural iniury 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 70334 2010

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

SEP 072010

2835 Smith Ave, Swite 203. Baltimore, MD 21209

32. Registrar's Signature

			. For	Please				delible Ink. artment of H		-		gible.		
			1 - State Registrar				Cei	tificate of L	Death		Reg. No.2	110	27773	
ı	Physici /Medi		1. Decedent's Name (Fin Deloras		•	?				2. Date of De Month Augus	Day	2010	3. Time of Death 8:55a M	
	Examir		4a. Facility Name (If not Rivervi			•	r	4b. City, Town, or Essex	Location of Death		4c. County of Death Baltimore			
	Funeral Director	i i	5. Social Security Number 218-24-84		ex □ M 2 <b>⊡</b> F	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct. 28	th ay, Year)	Year) 9. Birthplace (State or Foreign Country) MD		
	pui *		Usual Residence of Dec	edent . County		100 0	ty, Town or Lo	cotion						
	Aaryla f sho	ō		Baltim	ore	100.0	Essex						0d. Inside City Limits 1 Yes 2 No	
	the h	rect	10e. Street and Number		.010		H3562	10f. Zip Code			10g. Citizen of What Country?			
	h with	Funeral Director	610 Nor	ris L	ane			2122	1		USA			
	ems 2	iner	11. Marital Status		12. Was Dece	edent Ever in U	J.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc.			)- 14. R	ace - America lack, White, e		
215-0036	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show coloral Examinar must be notified at	by	1 Never Married  Widowed 4	_	1 □Yes If Yes, Giv Year or D	2 <b>∏</b> No ∕e		1 ☐ Yes 2 🕱 No	Specify:		Spec		ite	
5-0	72 ho	etec	15. I (Specify or	Decedent's Ed	ucation de completed)		(Give	lent's Usual Occupa	uring most of worki	ing	16b. Kind of	Business/Ind	ustry	
2	s 1 and 2 should be filed within 72 hours f Hauth and Mental Hygiene. Item 27 Is marked other than "naturel", other treumatic event, the Medical Exa	Completed	Elementary/Secondary	/ (0-12)	College (1	1-4or 5+)	life. I	duct Wor	_		MD S	pecia	l Wire	
pu	tat Hyd oth	Be	17. Father's Name (First,						18. Mother's Name			ame)		
Σ	should nd Men marke imatic	2	James D				405 14-10	Add (0)		e L. I				
Maryland	har har 7 ls		Mark Bal			n_law		g Address (Street a					Code)	
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: if Item 27 any Injury or other tru 900.		20a. Method of Disposition	on emation 3	Removal from	20b. I	Place of Dispo	sition (Name of natory or other place	9) 0/2	more Moate	20c. Location	21 n - City or Tov imore		
altin	mit. Partmer partmer portent / Injury	Bayview Crematory 8/31/10 Baltimore MD  21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto.												
ä	2 2 E 8		- Katu	to R	Pin	1		Connell						
	Physician /Medical Examiner	ner	23a. Part1. Enter the dis shock, or heart fail immediate Cause (Final disease or condition resulting in death)  Sequentially list condition any, leading to immedicause. Enter Underlying Cause, (Disease or injury Cause, (Disease or injury)	ure. List only	a	(or as a consection of the con	dior	onicob		Arre	st	ease.	Approximate Interval Between Onset and Death	
Box 68760,	Attending Physiclan: The law requires that the death certificate be executed to death. To death. After this certificate has been signed by the attending physician and sorter: Atter this certificate has been signed by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preg	l	d23c. If yes, out		ancy		= 5		23d. [	Date of deliver	y	
P.O. B	that the death ed by the atte detached for	hysicia	in the past 12 ment 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			wirth 2 Feta ant at time of coown		Ectopic pregnancy Other (specify)			1		Day Year	
	w requires that been signed to should be det	by	Part II. Other significant			eath but not res			n in Part I.				e cause of death?	
Vital Records,	nysiclan: The law re nis certificate has bee I director, page 2 sho	Completed								24a. Was autor perfo	osy ormed2	prior to com death?	sy findings available ipletion of cause of	
/ita	clan: ertifica	Be (	25. Was case referred to examiner?	medical					26. Place of Death				4	
of	ding Physia h. After this or funeral dire	ို	1 Yes 2 No 27. Manner of Death 1 Natural 5	Pending investigation		npatient 2 C of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	at at	me 5 🗌 Resid 28d. Describe l			)	
Division		Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	286. Place	of Injury - At h ng, etc. (Specii	ome, farm, stre fy)	eet, factory, office		28f. Location (: City or Tox		mber or Rural	Route Number,	
	To the Hospitel or within 24 hours after to the Funerel Dir completely filled in	Medical C	29a. Certifier 1 (Check only 2 0ne)	Certifying Ph Medical Exam	ysician: To the iner: On the ba and mann	asis of examina	owledge, death ation and/or inv	occurred at the tim restigation, in my op	e, date and place, a inion, death occurre	and due to the ed at the time,	cause(s) and r date and place	manner as sta e, and due to	ated. the cause(s)	
	To th within To th comp	M	29b. Signature and title of	of certifier	M.D			29c. License	number		29d. Date sign	_ '		
•				w.				D	69540		81		010	
			30. Name and address of		completed caus	e of death (Iter	п 23а) (Туре,	Print) Le go do	Rel S	uito >	04 P	WK.	11234 112 MD	
	Sta	te	31. Data filed (Month, Da	WY 91010	32. R	egistrar's Sig	ature Jan	W	, – ) (	- 02 /	, ,	-4-10	- , , ,	
	Registr	ar	SEL A	1 2010	1 BAN	مر پ	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 2, Russell Kenneth French 2010 3:45 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign October 14. Hours 213-94-4699 37 Director Maryland 1972 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Derwood 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 9 Anamosa Court 20855 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Human Resource Manager Survey Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dwight Kenneth French Linda Shellev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marla D. French / Wife 9 Anamosa Court, Derwood, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. Date 4, 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State 2010 Montgomery Crematorium, Inc 4 Donation 5 Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licenses r<sup>22</sup>, Name and Address of Facility Funeral Home/Rockville, Inc. Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ Lymphoid Leukemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Day Yes 2 No by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 🗵 No 3 ☐ Probably 4 🗍 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy pade performed? Yes 2 X No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Hospital မှ Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Hospice IPU 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident within 24 hours after death To the Funeral Director: ompleted filled in by the Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R115108 September 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Diane Ruckert, CRNP

32. Registrar's gnature

6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Day Physician/ 6:18 P M **3**0 2010 LUCINDA **AMELIA** FLOYD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALTIMORE 3120 GREENMEAD RD 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** (Month, Day, Year) 09/11/1907 Hours Country) 1 □ M 2 🕱 F Director 219-22-5547 102 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1
▼ Yes 2 □ No BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1914 HARLEM AVENUE 21217 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 XWidowed 4 Divorced BLACK Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DAYCARE PROVIDER EARLY CHILDHOOD ED. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ ELIZA SLIGH JAMES BOOZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YVONNE FLOYD PRIDE/DAUGHTER 3516 LYNNE HAVEN DR. WINDSOR MILL, MD Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/8/2010 GARRISON FOREST CEM. OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST BALTIMORE. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Cervila Ph\_sician/ 09 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner rt any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and trar Due to (or as a consequence of): -burialattending physician Physician/Medical 09 Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Unknown Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No certificate 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: director, Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 2 No ပ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accider work? 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title tusustma 0 peewer upo 2010

State Registrar

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Name and add

Hu Sustana
31. Date filed (Month, Day, Year)

CRMA GNP. ET

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Carmello Gus Fertitta <u>7:32</u>₹ 201 Medical September 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore <u>Greater Baltimore Medical</u> Cente Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 216-32-0899 1 **X**M 2 □ F Days Hours 87 Months 8/31/1923 Mary land **Director** Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Towson 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 216 Beech View Court 21286 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 K Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N College (1-4 or 5+) Giant Food Produce Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Fertitta Marie Marsigila 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Haynsworth / Daughter 216 Beech View Court Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 9/10/2010 Baltimore, Maryland Signature of Euneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last 251 and tran Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Special) ICU 1 ☐ Yes 2 XNo Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier License number 29d. Date signed (Month. Dav. Year) 5020 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kebedo 31. Date filed (Month, Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician/ 0 Medical ty Name (if not institution, give street and number, 4c. County of Death Examiner DWN el 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) last birthday, Age (In **Funeral** Months Days Hours **Director** Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 🗆 No 10g. Citizen of What Country? 10e, Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Never Married 2 Married ð 21215-0036 2 2 No 1 🗌 Yes Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday, (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname, Maryland 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NO Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GEN Burnies 9,200 22. Name and Address of Facility 405 ure of Funeral Service Licensee eto. mg, 21229 ace 23a. Part . Enty the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph\_sician/ Medical Due to (or as a cons a uence of **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exect, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tra resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work' 5 Pending 1 🗌 Yes 2 🗌 No Investigation
6 Could not be Accident 🗆 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier e of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registra State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Menth 9 4:25 Physician/ 2 2010 ам Edward L. Gilchrist Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number yrs. last birthday) 8. Date of Birth Age (In yrs 86 **Funeral** 1**X** M 2 □ F (Month, Day, Ye 217-12-3955 1924 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director N/AMD Baltimore 1 Yes 2 No 10f. Zip Code 21213 10g. Citizen of What Country? 10e. Street and Number Funeral 1904 E. Federal St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces? African 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 No Specify: Specify: Amer. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Uniform Co. Elementary/Seconday (0-12) College (1-4 or 5+) Superior 8 Be 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Jones 17. Father's Name (First, Middle, Last) Lancer Gilchrist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 69 Serpens Rd, Balt., MD 21237 19a. Informant's Name/Relationship (Type, Print) Shelley Gilchrist/Daughter 20c. Location - City or Town, State Arbutus, MD 20b. Place of Disposition (Name of 20a Method of Disposition 9/11/<sup>Date</sup>10 Arbutus Mem. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Fun ral Socice License 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) endionio Medical Due to (or as a consequence : 1: Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month 4 Pregnant signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ ancingon awni 3 Probably 4 ☐ Unknown 1 Yes 2 🗌 No should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 1 ☐ Yes 2 ☐ No certificate Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 1 Natural 28d. Describe how injury occurred Certificate: injury 5 Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only or 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death September 2, 2010 Physician/ 7:10 Рм Peter A. Gubser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** May 9, 1941 Months Days Hours Min. 1 ₺ M 2 🗆 F OkTahoma 69 444-42-8872 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Examiner must be notified Chevy Chase 1 X Yes 2 No 28a-f Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number 23a 20815 Funeral 4517 Cumberland Avenue United States items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: I fiten 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin any injury or other traumatic event, the Medical Examin 1 Never Married 2 X Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Non-Profit Political Scientist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Douglass Eugene Gubser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 4517 Cumberland Ave., Chevy Chase, Maryland 20815 Annie Y. Gubser/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept. Date 5. Montgomery Crematorium, Inc. 1 🗌 Burial 2 🔀 Cremation 3 🗆 Removal from State Bethesda, Maryland 2010 4 Donation 5 Other (Specify) Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 Signature of Funeral Service Licensee M00198 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 days Immediate Cause (Final √h sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Cause (Disease or linjury ig physician and as the burial-tran 0 that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending properties of IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No certificate has been signed by the irector, page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metastatic Prostate Cancer 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Coagulopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 ₺ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🔀 No ည 1 Main Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury 1 X Natural 5 Pending 1 Yes 2 No Accident ☐ Acciden☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

Registrar DHMH 17 Rev 7/2009

State

only one

Eric Park, M.D. 31. Date filed (Month, Day, Year)

SFP 0 7 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature

2010

2

September

8600 Old Georgetown Road, Bethesda, Maryland

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D0060117

29d. Date signed (Month, Day, Year)

September 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day GANTSIDE SE 9:30 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TrVIE an everno EVIMA If Under 1 Year | If Under 2 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 🖾 M 2 🗆 F 68 220-38-6003 Yrs. Director Maryland 30,1941 Sept. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Severna Park Director MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 Truck House Road 21146 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Automotive Repair Elementary/Secondary (0-12) College (1-4or 5+) Automobile Painter Body and Fender Shop 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brent W. Gartside Marie Dorn ဂ္ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Romancoke Road Stevensville, MD 21666 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 Is
any injury or other trau Russell Gartside (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/3/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funda Service Lense <sup>22</sup> Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -archon 110 Cardia **Physician** / h /Medical Due to ( r as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels consequence of Examiner sician and burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hosnital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2[**V**No 2 ER/Outpatient 3 DOA 2 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attend 24 hours after death. Funeral Director: A death. 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

To the Hospital within 24 hours a To the Funeral C

State Registrar

Medical

29b. Signature and title of certifier

CRNO 24 Truckbrune DIANA NO 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(An

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

R104317

29d. Date signed (Month, Day, Year)

Severna Park, mD 21146

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

601

Veterans

297

31. Date filed (Month, Day, Jear)

D57531

y pullersurlle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Charmaine Halsey 2010 27782 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 26, 2010 2125 hrs Medical Examiner Charmaine Antasha Halsev 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Hours Months Days Director Country) MD 2X F 220-86-5118 1 M 34 Yrs 02/11/1976 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f show "natural", or items 23a or 28a-f shov Examiner must be notified at once. MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Baltimore Co Randallstown Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Sulky Ct. Apt T2 21133 S.A Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes 3 Widowed 4 XDivorced Yes, Give Year 1 Yes 2 No specify: Specify: Black þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 years Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James Vernon Halsey Gaynell House ပ 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GaynellHouse(mother) 6144 Radacke Ave., Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Josephor Brown F/H And Crematory 1 Burial 2 K Cremation 3 Removal from State 09/02/10 Baltimore, MD Donation 5 Other Specify: <sup>22</sup> Joseph Mes Brown Jr. Funeral Home PA 2140 N Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Wedical Death Seizure disorder Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a, X UNPENDED by the attending physician ached for use as the burial 27,per ME G908 10/21/10 TT The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown Unknown signed by t be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed s peen s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has death? performed After this certificate funeral director, page Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Director: , 5 Pending 1 Yes 2 No after death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 24 hours a (Specify) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 27, 2010 Brasall 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Redistrer's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

**OCME** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 07:50 PM September 2010 Jeff L. Haye 01 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore N/A OF Hospital Baltimore If Under 1 Year If Under 24 Hrs. Chate of Birth (Month, Day, Year) March 1947 9. Birthplace (State or Foreign Country), Jamaica 5. Social Security Number 7. Age (In yrs. last birthday, Funeral 1 XM 2 □ F Director 63 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🗌 No unk unk unk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral unk unk unk 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married Completed by Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black If Yes. Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Laborer Self Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Mary unk Amos Haye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John Harris(bestfriend) 5301 Reisterstown Rd., Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State oséphi Brown F/H And Crematory 1 Burial 2 Kremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/03/10 Baltimore, MD 21. Signature of Funeral Service Licensee <sup>22</sup>Josephi<sup>dre</sup>H. Brown Jr. Funeral HOme PA 2140 N Fulton Ave., Baltimore, MD 21217 Muamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ 4 days disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b I director, page 2 sh autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 \_\_ Certifying Nurse Practioner To the best of my knowledge, death consisted at the fine date and place, and due to the nause(s) and n 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010 RES-000 september 1 Kishpreet Kaur MBBS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

KAUR

ARSHPREET
31. Date filed (Month, Day, Year)

SEP 072010

MBBS

32. Registrar's Signatur

Sinai Hospital of Baltimore

10-06594 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rhonda Hamilton State of Maryland / Department of Health and Mental Hygiene 2010 27784 1- For State Certificate of Death Registrar 2. Date of Death Name (First, Middle,Last 3. Time of Death Physician/ Month Medical Examiner 1208 hrs amilton September 1, 2010 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 2006 Divison Street **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Davs Hours 2 **X**F Country) Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location Yes 2 No altimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country vision Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Armed Forces? White, etc. Never Married 2 Married 2 No 1 Yes Black If Yes, Give Year 1 Yes 2 No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industr Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 11th vursing 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Mid dle. Maiden Surname) OOK Informant's Name/Relationship (Type, Print ) 19b. Mailing Address Itimore, MD Vells Manor Ave. Mother Method of Disposition Burial 2 Cremation 3 Removal from State Dutus Donation 5 Other Specify ignature of Firm ral Service License 23a. Part I. Intenthe disease, or complications that caused the death. Do not enter the mole of dying, Approximate Interval **Physician** failure, bist only one cause on each line Between Onset and /Medical Death Heroin intoxication and cocaine use Immediate Cause (Final disease Ėxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and cian/Medical tending physician a X UNPENDED AMENDED PII, 27, 28a-f, per ME g907 9.28.10 TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown signed by the detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? φ 1 Yes 2 No 3 Probably 4 Unknown Hyperthemia Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death' Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Pending Fd 11:56 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2006 Division Street Baltimore, MD 6 X Could not be Suicide house determined (Specify) 4 Homicide 29a. Certifier 1 (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 2, 2010 30. Name and address of erson who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registra

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. 100 N. Second St., P.O. Box 66 Woodsboro, MD21798 Lawrence Dorsey Jr./ nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Woodsboro, MD Mount Hope Cemetery 9/1/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home 404 S. Main St. Woodsboro, MD 21798 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on DENENTIA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 X No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Ye ar Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 2 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur 00062223 8/31/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRAYEEN BY LARUM, NO 1967T M 1967 THUVE, FREIEUCE, MD 4702. 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar Denve S. park DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

7. Age (In yrs. last birthday)

95

Yrs

10c. City, Town or Location

4b. City, Town, or Location of Death

Days

Woodsboro

1 ☐ Yes 2X No Specify:

clerk

(Give kind of work done during most of working life. DO NOT use retired)

10f, Zip Code

16a. Decedent's Usual Occupation

Braddock Heights If Under 1 Year | If Under 24 Hrs.

Hours

21798

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

2. Date of Death

8. Date of Birth (Month, Day, Year)

21,

Month

August

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Shorb

Day

2010

Frederick

U.S.A.

14. Race - American Indian, Black, White, etc.

retail store

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

1915

4:30 P

10d. Inside City Limits

1 X Yes 2 ☐ No

Birthplace (State or Foreign
Country)

Maryland

White

27

**Physician** /Medical Examiner

**Funeral** 

1 - For State Registrar

10a. State

Maryland

10e. Street and Number

5. Social Security Number

217-18-7293 Usual Residence of Decedent

1. Decedent's Name (First, Middle, Last)

Mary Louise Dorsey Hiltabridle

1 □ M 2 🗷 F

Frederick

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No

College (1-4or 5+)

4a. Facility Name (If not institution, give street and number)

Vindobona Nursing Home

102 Elizabeth St.

15. Decedent's Education (Specify only highest grade completed)

1 Never Married 2 Married

3 XWidowed 4 ☐ Divorced

Elementary/Secondary (0-12)

Owen Dorsey

17. Father's Name (First, Middle, Last)

Director or 28a-f show r than "natural", or items 23a or 28a-f sho 10'

Director

Funeral

ģ

Completed

Be

2

and Mental Hygiene.

1. Decedent's Name (First, Middle, Last)

**Physician** 3 2010 7:30 A September Sr. Jesse Lee Hoover /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 17404 Onax Drive Germantown Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** Days Hours 1 🔀 M 2 🗆 F Yrs. Maryland 64 31, 1946 Director 217-44-2931 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 1XYes 2 No Director Maryland Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20874 17404 Onax Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: 1964-67 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: δ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) postal service 12 truck driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Waunita L. Shumaker ပ Layton B. Hoover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Germantown, MD 20874 17404 Onax Dr. Rhonda Smith/daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Shurial 2 ☐ Cremation 3 ☐ Removal from State 9/8/2010 Hagerstown, MD Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licenses athanine ( 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** weeks Hodgkins lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 chronic obstructive pulmonary disease 1 X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an perform 1 ☐Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A BALL September 3, 2010 D53317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gaithersburg, MD 20877 Joseph Ball 16220 Frederick Rd., #213 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2010

Day

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death august Physician/ Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hon Boltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Venture) 9. Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ral", or items? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) (France) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a, Method of Disposition 20b. Place of Disposition (Name of Department of matory or other place 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Sign re of Funeral Service Licens Name and Address of Facility 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ENW Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner em. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 L 9 Unknown 2 No detached P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atribut 12/1/2006 Com 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown maritran 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy tim tion performed within 24 hours after death.

To the Funeral Director; After this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: filled in by the funeral director, 25. Was case refe red to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 욘 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29c. License number D63170 2010 29 30. Name and address of person who completed cause of death (#em 23a) (Type, Print) SIM Honpital of Baltimor 32. Registrar's signatu State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 Year 13.20 PM 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Hospita Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1 - M 2 M F Months Days Min. Hours Country) Director Yrs. 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ier must be notified 1 Yes 2 No timor 10e. Street and Numbe 10g. Citizen of What Country? Funeral a 96 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give "natural", or iterr ledical Examiner n 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ emosthenes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural oute Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility + Cremation Services Chapei d Road Funeral C Evans Parkville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Conquetille disease or condition resulting in death) CCW 1 Medical Due to (or as a consequence of): Examiner monthe Sequentially list conditions, Examine cause (Disease or linjury Due to for as a consequence of, ailure To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Neeke that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 1 No Yes 2 ₩No 1 Tes Be Vital 25. Was case referred to medica 26. Place of Death (Check only one) Hospita 2 1 No Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 28a. Date of injury Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number P24069 09.02.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FORALE 900 cato Muenue Date filed (Month, Day, Year, State 32. Registrar's Signature 7 2010 Registrar

HARTNEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Charlotte Merryman Harrison 2010 6:40 AM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Oak Crest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Months Days Hours Min. 1 □ M 2 🗓 F 100 213-38-5637 Yrs. March 14, 1910 Towson, MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Parkville 1 Yes 2 No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 U.S.A. 8834 Walther Blvd. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 X Widowed 4 Divorced 6b. Kind of Business/Industry

Baltimore County 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 1 2 Teacher Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry E. Merryman Martha P. Parks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1404 Walker Road, Freeland, MD 21053 Ellsworth Harrison/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 2010 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, Maryland 21234 Pirt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he ift failure. List only one cause on each line. Approximate Interval Between Onset and Death thme late Cause (Final dim se or condition resulting in death) meumonia 8/30/2010 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardiovascular Diserse Hypertensive 2 No 3 ☐ Probably 4 ☐ Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 ☐ Yes 1 □Yes 2 🖺 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes → No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) MN.P.

Mortotte Division of Vital P **Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Experient must be notified at

marked other than

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Department of Health a Important: If item 27 is any injury or other tra

**Physician** 

/Medical

Examiner

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led by the attending properties detached for use as

signed by 1

After this certificate has funeral director, page 2 s

d in by the f

within 24 hours a

To the Funeral C

completely filled

death.

Examine

Completed by Physician/Medical

Be

Certification: To

Medical

29b. Signature and title of certifier

30. Name an address of person

31. Date filed (Month, Day, Year)

SEP 0 7 2010

Micheelle G. Harrison CRNP

72 hours after death

21215-0036

Baltimore, Maryland

9

Pages 1 and 2

Health

Director

Funeral

Completed by

Be

State Registrar DHMH 17 Rev 1/2001 WILL MISN

who completed cause of death (Item 23a) (Type, Print)

29c. License number

R171944

8800 Walther Blod, Parkrille MD 21234

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph John Herold, Sr. Month Year 4: 15 August 2010 AM 21 Medical 4a. Facility Name (if not institution, give street and number)
Union Memorial Hospital 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore City N/A 6. Sex 1 X 3 M 2 □ F Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 26, 1930 Director Yrs Maryland 214-26-2719 80 Usual Residence of Decedent 28a-f shov 10b. County 10a State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore City 6 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a Funeral 4329 Roberton Avenue 21206 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black. White, etc. 1 Never Married 2 Married Completed by 1XXYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: marked other than "natural", 3 😾 Widowed 4 🗌 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Machine Shop 8 Years Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph J. Herold Maria Gechleine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4329 Roberton Ave. Baltimore, Maryland S permit. Page 1 and 2 st Department of Health a Important: If item 27 is Jessica Lassiter (Granddaughter) 21206 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗖 Removal from State cemetery, crematory or other place) Oak Lawn Cemetery 8/31/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses <sup>22</sup> Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Preumonia disease or condition days Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown ed by the a g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No 1 🗌 Yes ျု 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Records, **Division of Vital** within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

Box 68760

P.O.

State Registrar 29b. Signature and title of certifier

MAJO

Maid heijal, M.O

ALFREIJAT.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signatu

DHMH 17 Rev 7/2009

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

AT 243 8946

Chiun Memorial Hospital, 201 E. University Akmy, Baltimore, MD 21218-2895

08,27,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Aŭg 2:15P M Julia Τ. Hawkins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NA Baltimore <u>Future Care Lochearn</u> 7. Age (In yrs. last birthday) 87 yrs. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2XXF Months Hours 02-06-2 220-20-0467 Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21215 4801 Seton Drive . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian,
Black, White, etc. African XXNever Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Specify: American 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) John Hopkins Elementary/Seconday (0-12) College (1-4 or 5+) Research Chemist Hospital 12th Grade 4vrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Briscoe Charles Hawkins Lena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 1111 Whitmore Avenue Apt. #201 Baltimore, MD Adrienne Wilson-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 09-03-10 Lansdowne, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lie 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore, MD 21217 23. Part 1. Enter the disease, or compensations that caused the yearth. Do not year the mode of dying, such a pardiac or respirato yearest shock, or heart failure. List only ne cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Ons Death Physician Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of). Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 1 ☐ Yes 2 ☐ No funeral director, page 2 should within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform лiπed? 2 X N 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes Investigation Accident 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature

30. Name and address of pe

MERULTI

rson who completed cause of death (Item 23a) (Type, Print)

10093

29d. Date signed (Month, Day, Year)

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MITHOLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 9:10 31  $P^{M}$ Hla Htu August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16824 Malabar Street Derwood Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days May 5, 193 1 🕅 M 2 🗆 Director 216-63-4932 73 Burma Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 X No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16824 Malabar Street 20855 Burma 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 X Married Completed by 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian 3 Divorced 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.] 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Radiologist Radiology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ba Shin San Myint 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zaw Oo/Son 16824 Malabar Street, Derwood, Maryland 20855 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State September 4 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland Signature of Funeral Service Licen Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Bethesda-Chevy Maryland 20814 Chase, Inc. Haron M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death
Year Immediate Cause (Final Physician/ Metastatic Cholangio Carcinoma disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death Yes 2 No. Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 X No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No ieral Director: / filled in by the f Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature ar 29c. License number 29d. Date signed (Month, Day, Year) D38262 September 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta, M.D. 2401 Research Bouleyard #330 Rockville, Maryland 20850

DHMH 17 Rev 7/2009

State Registrar 32 Registrar's Ignat

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State of Maryland / Department of Health and Mental Hygiene

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	the Na or 2	٥	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	untry?	
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Baltimore, Maryland	permit. Page 1 a Department of H Important: If ite any injury or ot	3	21. Signature of Funeral Service Unise	M0/60							7 Chase, Inc. 0814-3501	
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27. Manner of Death  1 X Natural  2 Accident  3 Suicide  4 Homicide  28a. Date of injury  (Month, Day, Year)  28b. Time of injury at work?  M 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred								Cocanica				
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the within 42 hours after feath.  To the Funeral Director feath.  Completed filled in by the funeral director, page 2 should be detached.		4 Homicide determined 28e. Plac build	e of Injury - At hor ling, etc. <i>(Specify)</i>	)			City or Tov	vn, State)		al Route Number,	
	e Hosp 124 hot e Fune deted fil	Medical	29a. Certifier (Check (Check only one) (Check one) (Check only one) (Check one) (Ch	isis of examination	and/or investi	gation, in my opinio	n, death occurred	at the time, date a	and place,	and due to the ca	ause(s) and manner stated.	
	To th withir To th comp	~	29b. Signature and title of certifier	0	1	29c. License				e signed (Month,		
			Clan K	Sear	W M	) D5226	51		09/0	1/2010		
7			30. Name and address of person who completed cau	I.			· C	м -	1 0	0006		
7	Stat	e	31. Date filed (Month, Day, Year) 32. I			le Silver	s Spring,	Maryla	nd 20	0906		
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DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 10 Month Q 2140 Dolores С. Hoover 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital. Baltimore n/a If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Feb. 4, 1934 9. Birthplace (State or Foreign Min. 1 M 2 F Months 215-32-0572 76 Yrs Marvaand Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD **Baltimore** Monkton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4032 Stansbury Mill Road 21111 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Floral Designer Flower 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Clayton Alice Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Charles D. Hoover-husband 4032 Stansbury Mill Rd., Monkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Bel Air Memorial 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 9/8/10 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Icensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischaemic disease or condition resulting in death) Sequentially list conditions If any, leading to immediate cause. Enter Underlying Coronary Due to (or as a consequ Cause (Disease or linjury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician/ Medical **Examiner** 

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Physician/

Medical

**Examiner** 

**Funeral** 

Director

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ed other than "natural", or items 23a or event, the M dical Examiner must be

should be filed within 72 hen and Mental Hygiene. 7 is marked other than "na

permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev

Baltimore,

Division of Vital Records, P.O. Box 68760

Director

Funeral

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Completed

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hours after death with the Maryland

Examiner Physician/Medical IF FEMALE: þ Completed

Gastrointenstinal Bleed, Obstructive sleep appea Endstage kidney Disease, congestive Heart failure

istrar's Signature

24a. Was an autopsy

28f. Location (Street and Number or Rural Route Number,

Yes 2 No

City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical 1 Tes 2 No 27. Manner of Death

29b. Signature and title of certifier

28a. Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be

28c. Injury at work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 Yes

29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Natural

2 Accident
3 Suicide

4 Homicide

RESDOO

September 02,2010.

SOLIHOU, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

SANTOSH DHITAL. 5601 Loch Raven Blud MD-21239 Good Samonitan Hospital.

State Registrar

DHMH 17 Rev 7/2009

To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu

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Certificate:

Medical

28b. Time of

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			For State Registrar			Ce	rtificate	of L	Death		2. Date of De	Reg. No	2010	27795	5
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d	Examin		4a. Facility Name (If not institution Genesis-Cromwe	-			4b. City, Town, or Location of Death Parkville					4c.	County of Dea Balti	more	
#00 m	Funeral Director		5. Social Security Number 218-14-9945	6. Sex 1 ★ M 2 □ F	7. Age (In yi 85	rs, last birthday Yrs.		Year Days	If Under Hours	Min.	8. Date of Bird Sept 1	th 12 Year) 6, I	924 Ma	thplace (State or Foreig ountry) ryland	חן
	ow at		Usual Residence of Decedent  10a, State 10b. County		10c. (	City, Town or L		_						10d. Inside City Limits	s
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	th with the 23a or 2 ust be no	al Dire	10e. Street and Number 2707 Placid A	Avenue			10f. Zip (	2123	34			10g. Cit	U.S.A		
36	3 5	by Funeral Director	11. Marital Status  1 □ Never Married 2XXMar  3 □ Widowed 4 □ Divorced	If Yes. Gi	orces? 2∐ No ve	U.S. 13.	Was Decede If Yes, speci 1 □ Yes 2		ispanic Oi in, Mexica Specify		ecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi Specify:		
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Maryland	Armed Forces?    The part of t														
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Ō	permit Depart Import any in		21. Signature of Funeral Service				1050	York	Rd.	, To	wson, M	ID 2	21204	Home, Inc.	
2.00	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	_a. U	om	eath. Do not elegath. Do not elegath.	nter the mode	of dyir	g, such a	s cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death	
68760,	examiner be executed physician and sthe burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Due to (or as a consequence of):													
.O. Box 68	death certif e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2□F nant at time o	etal death 3	□Ectopic pre □ Other (spe		′				23d. Date of d Month	elivery Day Year	
Δ.	ires that signed by be deta	b	Part II. Other significant conditi	ions contributing to c	leath but not i	resulting in the	underlying ca	use giv	en in Part	1.				to the cause of death?  Probably / 4 □Unknow	vn
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Vital	slcian: The la certificate ha rector, page 2	Be	25. Was case referred to medica examiner?	Hospital:				Oth	er'		th (Check only				_
O	ding Phys n. After this funeral dii	n: To	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time		Bc. Injui Wor	4110	lureing fl	ome 5∐Res 28d. Describe		6 □Other (Sp ury occurred	pecify)	
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	To the within 2 To the complex	29b. Signature and title of certifler  29c. License number  29d. Date signed (Month, D									nth, Day, Year)				
4			30. Name and address of person	Fult	20	5 T	ow B	The	JI	02	12/04.	_7	10,01	ter	
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7:43 AM

1 XYes 2 No

Interval Between Onset and Death

Day

September 0;

2081

Year

2010

Registrar DHMH 17 Rev 7/2009

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32. Remar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUDHIR.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year AUGUST **Physician** 12:38 F.M Wara olano 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 24, 1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 219-52-5233 62 1947 Director Usual Residence of Decedent with the Maryland 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 7 No Directo Maryland Baltimore Idlewyde 10e. Street and Number 10f. Zip-Code 10g, Citizen of What Country? "natural", or items 23a e Funeral 21239 1019 St. Albans Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) z snow and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Banking years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Roland Jones, Sr. Carrie Evelyn Woods ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 1019 St. Albans Road Baltimore, Maryland (wife) 21239 Sheila M. Jones item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl once. 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory 4 Donation 5 Other (Specify) 8-31-10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part 1. Edger the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.

MITCHEII—Wiedereld Funeral H
6500 York Road Baltimore,

Do not enter the mode of dying, such as cardiac or respiratory arrest, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death Immediate Cause (Final leukemia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death Year 5 Other (specify) 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury

"footh Day Year) 27. Manner of Death 1 Natural 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 🗌 Yes 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Pay, Year) SEP 0 7 20

rist

32. Region 's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOT

600 North Wolfe St, Baltimore, MD, 21287

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AÜĞÜST 20TO 8:20 а м **JENNINGS** HENRY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Temple Hills 2713 Fairlawn St. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 11 M 2 □ F Months Hours (Month, Day, Year y 4, 1930 North Carolina Director 241-38-0933 80 May Usual Residence of Decedent show or 28a-f shove notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD PRINCE GEORGES TEMPLE HILLS 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 2713 FAIRLAWN STREET 20748 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Yes 2XXNo Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: BLACK If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) BUILDING ENGINEER DC GOVERNMENT d 2 should be filed with alth and Mental Hygien 27 is marked other tl 11TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NATHANIEL JENNINGS IDA CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau BETTY J. JENNINGS/WIFE 2713 FAIRLAWN STREET TEMPLE HILLS, MD 20748 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 09/07/2010 SUITLAND, MD 22. Name and Address of Facility MARSHALL'S FUNERAL HOME 21. Signature of Funeral Service Licenses 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ End Stage Prostatic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical certificate be P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Pregnant at time of death the 9 Unknown 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Chronic Obstructive Pulmonary Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Alcohol Abuse, Depression Jas autonsv 24 hours after deatn.

3 Funeral Director: After this certificate Fleted filled in by the funeral director, page Yes 2 X No 1 Yes 2 No or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 🔀 No 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35345 9/2/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Waldorf,

Old Washington Rd.

32. Registrar's Signature

MD

Leop

George

31. Date filed (Month, Day

3261

10-06606 Alton N. Joyner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are	Legible.	07700
Please Type or Print in Black Indelible Ink. Ensure All Copies Are I State of Maryland / Department of Health and Mental Hygiene	2010	2//99

		1- For State Registrar	Cer	tificate of D	eath		Re	g. No.		-1173		
Physicia	an/	Decedent's Name (First, Middle,Last)					Date of Deat     Month	Day Yea		3. Time of Death		
ledical Exami		Alton N. Joyner  4a. Facility Name (if not institution, give s		1000	City, Town, or Lo	ti of Doot	Septembe	r 1, 2010 4c. County of	of Dooth	1738 hrs		
		4a. Facility Name (if not institution, give s St. Joseph Hospital	(reet and number)		owson	ocation of Deat	1	Baltimor		ity		
Funeral		Social Security Number     6. Sex	7. Age (In yrs. la	ast birthday)	f Under 1 Year	If Under 24Hr	s. 8. Date of Birt	h(MM/DD/YYYY				
Director		214-12-3663 IXM	2F	88 Yrs.	Months Days	Hours Mir	Aug 5,	1922	Foreign Cour	ntry) Maryland		
	ŀ	Usual Residence of Decedent		-			16 - ,					
v any		10a. State 10b. County	10c. City,	Town or Location						10d. Inside City Limits		
Maryland 28a-f show any d at once.	ě	Maryland Baltimor	e	Towso			L			1 Yes 2 No		
Mary r 28a- ed at	Director	10e. Street and Number	0		Of. Zip Code	0/	110	g. Citizen of Wh		у?		
th the Maryland 23a or 28a-f sho notified at once.		8428 Charles Valle	y Court Apt.  2. Was Decedent Ever in U.		212		pecify Yes or No-	USA L14 Basa		an Indian, Black,		
ath wi	Funeral	1 Never Married 2 Married	Armed Forces?		specify Cuban, I				e, etc.	ari iridiari, biack,		
her de		3 Widowed 4 X Divorced If	[X] Yes $2 $ No Yes, Give Year $1942 - 19$	)45 1□ Ye	s 2 X No	specify:		Specify:	Whi	te		
ours a atura	d b	15. Decedent's Education (Specify only	Dates.	16a. Decedent's U				16b. Kind of Bu	siness/Ind	dustry		
)36 thin 72 h ne. than "n edical E	ig ig	15. Decedent's Education (specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  2  Insurance Agent  Self En										
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examine	ompl		yea									
215-0036 be filed within 7 ntal Hygiene. rked other than	Be C	17. Father's Name (First, Middle, Last)  Joseph B. Joyner					e (First, Middle, M na Reve]		ĺ			
D 21215-003 should be filed within and Memal Hygiene. 7 is marked other thatic event, the Med	10	19a. Informant's Name/Relationship (Type	e, Print )	19b. Mailing Ad	dress (Street a	and Number or	Rural Route Num	ber, City or Tow	n, State, Z	Zip Code)		
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		Elizabeth A. Will	iams,Daughter	: 43 Bea	ver Pon	d Circl	e Parkvi	lle, MD	) 212	.34		
ore tra		20a, Method of Disposition  1 Burial 2 Cremation 3		Place of Disposition prematory or other p		="	Date	20c. Location -	·			
Page Page ment c		4 Departure 5 Other Specific	Met	ro Crema			03/10			Maryland		
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traum		21. Signature of Funeral Service Incense	Thomas Grego	or Crem	and Address of Ation \$	of Facility ociety	Of Maryl Baltimo	land, Ir	nc,	.1 01000		
	-	23a. Part I. Enter the disease, or complication		1499	rreaer1 node of dying, su	CK KOAC	or respiratory arre	ore, Mar	y Lan	Approximate Interval		
Physician Medical		failure. List only one cause on each	<sub>line.</sub> ultiple Injuries		, .					Between Onset and Death		
Examiner	- 1		e to (or as a consequence o	f):								
		Sequentially list conditions, b										
	ine	cause. Enter Underlying Cause	e to (or as a consequence o	r); ====================================								
sit d	Examiner	events resulting in death) Last	e to (or as a consequence o	f):	-							
xecuted n and I - transit		d. UNPENDED	AMENDED									
760, cate be execut physician and he burial - tra	Medical		23c. If yes, outcome of pregi	nancy				23d. Date of	delivery			
1876 rtifical ring ph		23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal o	leath 3	Ectopic pregn	ancy	Month	Da	y Year		
Box 687 ne death certific the attending produce as the	Sici	1 Yes 2 No 9 Unknown	Pregnant at time of de  Unknown	ath 5 Other	(Specify)					1		
that the dended by the detached f	Physician/		ontributing to death but not re	esulting in the unde	erlying cause giv	ren in Part I.	23e. Did to	bacco use contri	ibute to th	e cause of death?		
ires that the signed by I be detache	2						1 Yes	2 <b>✓</b> No 3	Proba	bly 4 Unknown		
ords, w require ts been si should t	ee						24a. Was a			ppsy findings available mpletion of cause of		
e law 1 e has t ge 2 sh	ompleted				_		autops perfor	med?	death?			
tal Recian: The certificate ector, page	ပ	25. Was case referred to medical			26.Place o	of Death (Check		i i i i	V Tes	2 140		
Vital Reco	o Be		pital: 1 Inpatient 2	ER/Outpatient 3	DOA O	ther Nursi	ng Home 5 1	Residence 6	Other:			
n of ling Ph After t funeral	-1	27. Manner of Death	28a. Date of Injury (Month, Day Year) Sep 1, 2010	28b. Time of Injur			28d. Describe h Pedestrian s					
ion ttendi leath ttor: / the fi	aţi	1 Natural 5 Pending 2 ✓ Accident Investigation		1652 hrs		s 2 V No						
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	ertification:	28e. Place of Injury - At home, farm, street, factory, office building, etc.  3 Suicide 6 Could not be determined 4 Homicide determined (Specify) Parking Lot  28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rung or Town, State) 1001 Cromwell Bridge Road, Tows										
ospita hours uneral y fille	O	29a Certifier										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: 0	n the basis of examination a	nd/or investigation,	in my opinion, o	death occurred	at the time, date a	and place, and d	ue to the	cause(s)		
To To con	Me	29b. Signature and title of certifier	nd manner stated.		29c. License	number		29d. Date sign	ed (Monti	h, Day, Year)		
	4	() (ashour			O.C.M	l.E.		September	2, 201	0		
VI		30. Name and address of person who cor			-							
' '	*		nt Medical Examiner	111 Penn St	reet, Baltime	ore, MD 212	201					
S Regis	tate trar	31. Date filed (Month, Day, Year) SEP 0 7 20	32. Registrar's Signatu	2	Mal							
ricgio	100	- U N R P	n well	10 1504	Car.							

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

10-06603 John Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 27800

in Jones		1- For State Criticate of Death		. No.	2100
Physicia	n/	Registrar  1. Decedent's Name (First, Middle Last)	2. Date of Death Month September		3. Time of Death 1612 hrs
edical Examir		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		1, 2010 4c. County of Death	1012 1113
		1721 Gwynn Falls Parkway Baltimore		NIA	<u> </u>
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min.	_	(MM/DD/YYYY) 9. Birn Foreig	n 4.4.1
Director	ŧ	217-82-0083 1 1 M 2 F 49 Yrs. Usual Residence of Decedent	Dune	25,1961 0	untry) Va.
* any	Ì	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits  1 XYes 2 No
yland a-f short	흱	Na. NA Baltimore  10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cour	
the Mar a or 28	eral Director	1721 Guyung Falls PKW4 21217		USF	7
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 17. Never Married 2 Married 2 Married 19. Marri		14. Race - Ameri White, etc.	can Indian, Black,
ter deat ", or it er mus	Fun	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No No specify:		Specify: B	ack
iours af natural Xamin	sq pa	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of volume most of working life, DO NOT use retired.)		16b. Kind of Business/I	ndustry
9036 within 72 hours after iene. ier than "natural", Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		THI	1P
5-0036 iled within 72 Hygiene. d other than the Medical	5	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Ma	aiden Surname)	
2121 hould be fil nd Mental I is marked atic event,	To Be	John Emanue Jones Ella 19a, Informant's Name/Relationship (Type, Print) 5,545 [19b. Mailing Address (Street and Number of F	Rural Route Numb	er, City or Town, State	Zip Code)
MD 2 d 2 shou lith and I n 27 is n		Ms. Robin Walker 16602 Ellsmere	2 Pl. A	t. Balto	M12/234
ore, s l an of Hea If ite		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Grant State  Grant Sta	Date 10 20 10	20c. Location - City or	Town, State
Baltimore, permit. Pages l an Department of Hee Important: If itel injury or other tr		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensele 22 Name and Address of Facility 30 Seph L. Russ	010010	Dwings	IVII IIS, Ma.
Balt permit. Departi Importinjury		titelle A. Hassis h. M. 12222 W. North A	uneral ve. Ba	Home, Fi	21216
Physician		23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
£xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Chronic Alcoholism  Due to (or as a consequence of):			
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
cuted nd transit	Ä	events resulting in death). Last Due to (or as a consequence of).	_		
60, ate be exe hysician a	Medical	UNPENDED AMENDED		Too a bar da ii	
O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	N/W	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of delivery  Month	Day Year
Box 687 death certific. the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown			
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of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by tuneral director, page 2 should be detach.	ed by	Hypertension	1 Yes	2 No 3 Prot	topsy findings available
cord	Completed		autops perform	y prior to oned? death?	completion of cause of
Recart The trificate or, page	e Cor	25. Was case referred to medical 26. Place of Death (Check	1 ✓ Yes 2 only one)	No 1 ✓ Ye	s 2 No
Vita hysician this cer	O Be	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin		tesidence 6 🗸 Other	: Scene
n of \ding Phy. h. After the funeral	on:	27. Manner of Death 28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work?  1 Ves 2 No	28d. Describe ho	ow injury occurred	
Division of Vital Records, P.O. also or Attending Physician: The law requires that the staff cleath.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ficati	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		reet and Number or Ru	rat Route Number, City
Div	Certification:	4 Homicide determined (Specify)	or Town, Sta		
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier (Check only only only only only only only only	I due to the cause at the time, date a	(s) and manner as statender and place, and due to the	ed. e cause(s)
To To con	Mec	and manner stated.  29b Signature and title of certifier  29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		( Catalons O.C.M.E.		September 2, 20	10
		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	01		
St	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature		<u>.                                      </u>	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2, 2010 Year Physician/ Dorothy P. Jenkins September 6:25 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Baltimore Examiner Stella Maris Hospice Timonium 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Days 1 M 2 X F Jume 1 7 ay, 1926 Mary I'and 212-22-7230 Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Baltimore Maryland Parkville 1 Yes aXX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8810 Walther Boulevard Apt. 1123 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Armed Forces' 1 Never Married 2 X Married ☐ Yes 2 No 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry Elementary/Seconday (0-12) Homemaker Own Home 10 permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important; If item 27 is marked othe any injury or other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Christian Hammerbacher Pauline Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Jenkins/Husband 8810 Walther Blvd. Apt. 1123 Parkville Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Gardens of Faith 9/7/10 Baltimore Maryland 5305 Harford Road 22. Name and Address of Facility Leonard J. Ruck, Inc. e of Funeral Service License Baltimore Maryland 21214 9 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2X No Month Year Day Pregnant at time of death eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NO Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 2 🗀 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral I Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2010 person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES. CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 7 2010

p.n.

SEPTEMBER

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland	-	artment of F tificate of		d Menta	l Hygie Reg.		27802	
ł	Physici /Medic		1. Decedent's Name (First, Middle,	ŕ	erdell	Joh	nson		2. Dat Mo Aug	e of Death nth ust 2	25, 2010	3. Time of Death 7:00 PM	
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, o	Airy			4c. County of Deat		
-100 - -100 -	Funeral Director		5. Social Security Number  526-34-9526  Usual Residence of Decedent	. Sex 7. Ag	ge (In yrs. la 75	st birthday) Yrs.	If Under 1 Year Months Days		Ain (Mc	e of Birth onth, Day, Ye ber 4,	9. Bird 1934 Arka	thplace (State or Foreign ountry) ansas	
	Maryland I-f show fled at	tor	10a. State 10b. County  Maryland Montg	omery		Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 No	
	h with the 23a or 28s st be noti	al Director	10e. Street and Number 14617 Bubbling	Spring Road	1		10f. Zip Code	20841			Citizen of What Co		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1		'	Mas Decedent of H f Yes, specify Cub 1 ☐ Yes 2X No		? (Specify Ye uerto Rican,	es or No- etc.)	14. Race - Ame Black, Whit Specify: W		
Maryland 21215-0036	ithin 72 houne. ne. <b>han "natura</b> • Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5+)	(Give life. L	dent's Usual Occup kind of work done OO NOT use retired	oation during most of d)	working	168	b. Kind of Business	•	
and 2	ould be filed w Mental Hygie arked other t atic event, th	To Be Co	12 17. Father's Name (First, Middle, La Garland Brown	ist)		поше	maker		Name (First, ys Yar		iden Surname)	=	
	and 2 should salth and Men n 27 is marke ier traumatic	Ĕ	19a. Informant's Name/Relationship Edward D. Johnso					and Number o	r Rural Route	Number, C	ity or Town, State, A	Zip Code) .and 20841	
Baltimore,	Pages 1 a nent of Hee int: If item iry or othe		20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe	☐Removal from State	ce	ice of Dispo metery, crer	sition (Name of natory or other place ational Ceme	ce) Oc	Date tober	200	c. Location - City or lington,	Town, State	
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Li	annust 1	101305	300	West Mont	gomery A	venue, F	Rockvill		120850–2805 Approximate Interval Between	
al V	Physician /Medical		23a. Pant. Exper the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  End Stage Respiratory Failure  Due to (or as a consequence of):										
	Examiner	er	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying		Obst	ructi	ve Pulmor	nary Di	sease			Years	
o,	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hyperte				Years					
68760,	rtificate be ng physicia as the bu	<b>Aedical</b>	Atrial Fibrillation  d. Atrial Fibrillation									Years	
P.O. Box	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1								livery Day Year		
	w requires that the de been signed by the s should be detached	ed by Pł	Part II. Other significant condition Depression, Gas	•					23	e. Did tobac		o the cause of death?	
Vital Records,		Complet	Gastroesophagea	1 Reflux, N	letabo	lic B	one Disea	ise	-	a. Was an autopsy performed Yes 2 🖸	24b. Were a prior to death?	utopsy findings available completion of cause of	
	Physician: The la r this certificate has ral director, page 2	To Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpati		R/Outpatier		ner: 4 🔀 Nursir		Residenc	ce 6 ∐Other (Spe	ecify)	
Division or	ding F n. After funer	Certification:	27. Manner of Death  1 N Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigat 6 Could no determin	be 28e. Place of in	ay Year)	28b. Time of Injury ne, farm, str	Wor	ry at rk? ∣Yes 2 □ No	28f. Lo		injury occurred et and Number or R State)	ural Route Number,	
۵	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	edical Cer		Physician: To the best caminer: On the basis of and manner si	of examinati								
	To the within 2 To the complet	Med	29b. Signature and title of confifier	Rei	el	M	D D C	se number	740	) 29d	Pate signed (Mon		
de			allen Re	no completed cause of	41	801	Print) //	tous	e sto	e l	-1, Free	elick, mo	
	Sta Registi		31. Date filed (Month, Day, Year)  SEP 0 7 2010	32. Regist	rar's Signati	ire barke	,						

**O**RIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:29 John Paul Kaniecki Рм September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1**X**M 2 □ F Months Days Hours Min 73 Director 212-36-7867 Maryland ebruary Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Marvland Harford Joppa 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22 01d Sound Rd. 21085 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XX Yes 2 \( \subseteq \text{No} \)
If Yes, Give Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 3 
Widowed 4 Divorced Specify: Year or Dates.1955-59 white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Central office technician telecommunications Be permit. Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, John Francis Kaniecki Catherine Olek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita V. Kaniecki/wife Old Sound Rd. Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem GardSep. 8,2010 | Timonium, Maryland 21. Signature of Funeral Service Licensee John O. Mitchell IV, Funeral Services of Dulaney Valley 200 E. Padonia Rd. Timonium, MD 21093 P.A of 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Oertifying Nurse Pra ctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month. Day. Year) 9010 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 500 upper chisapeake Medical Center Bei Air, mo Jordan Mathew 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Keeling Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HMUre Anne Arunde (1) cashington Social Security Number . Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country)Germany 1 M 2 X F Hours Director 216-08-7476 81 06/26/1929 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director "natural", or items 23a or 28a-f sl edical Examiner must be notified MD 1 ☐ Yes 2 💢 No Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , 23a c Funeral 1730 Leisure Lane 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Unknown Sperling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Yohanna Keeling / Daughter 1730 Leisure Lane Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 09/03/2010 4 Donation 5 Other (Specify) Glen Burnie, MD Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Avenue SW any in Glen Burnie, MD Singleton Funeral & Cremation Services, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or a la consequence of): Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Dav Pregnant at time of death 5 Other (specify) detached 9 Unknown Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 death? After this certificate 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manny of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 \( \text{Yes} 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar 29b. Signat

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Sept. 1, 11:41 AM James Knight, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Anne Arundel Baltimore Washington Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Georgia 8. Date of Birth **Funeral** (Month, Day, 1 🛛 M 2 🗆 Days Hours Min Director 256-48-0060 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City. Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 103 Benmere Rd. 21060 United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction permit. Page 1 and 2 should be filed witi Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, th Bricklayer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Bessie Pittman James Knight, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Benmere Rd. Glen Burnie, MD 21060 <u>Ann Knight / Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/4/2010 Glen Haven Mem. Park Glen Burnie, MD Signature of Runeral Service Licensee rkley-Ruddick Funeral Home, P.A. I Crain Hwy. SE; Glen Burnie, MD 21061 23a. Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cau, e on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) and De Ph sician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ signed by the atte in the past 12 months? Year Pregnant at time of death g 🗌 Unknown Part II, 9ther significant conditions contributing to eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 🗓 🖙 tifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one)

Registrar DHMH 17 Rev 7/2009

State

ITCH IR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C-V-C-RIAC M-D 8021 R TC-U

8021

KIAC M.D

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Yea 6.4 Otember Medical SOID 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death paltimore Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Min. Davs Months Hours (Month, Day, Country) 2 **Director** Usual Residence of Decedent 10a. State 10b. County 넒 10c. City, Town or Location Director be notified or 28a-f altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a Examiner must 716 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black White etc. ğ 1 Never Married 2 Married Yes 2 No and 2 should be filed within 72 hours after 21215-0036 1 ☐ Yes 2 🗹 No Specify: If Yes, Give 27 is marked other than "natural", traumatic event, the Medical Exa 3 🗓 Widowed 4 🗆 Divorced Specify: mite Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 10 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 SEPTEMBER Nothingham MD 2123 Important: If item 2 any injury or other once, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 □ Cremation 3 □ Removal from State 9-10-2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Partuille
8800 Harford Road Parkville Maryland 21234 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Ph\_sician/ DEMENTIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, and any to immediate cause. Enter Underlying Examiner Due to or as a consequence of -transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): as the burial by the attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month 1 Yes 2 X No ò Month Pregnant at time of death page 2 should be detached Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No Completed 1  $\square$  Yes 3 ☐ Probably 4 ☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 s autopsy perform Yes 2X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No ျင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULANEY VALLEY RD TIMONIUM. MD 21093 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

Interval Between

Onset and Death

Day

Year

1 Yes 2 No

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CATHERINE, KUCHTA SEPTEMBER Physician/ 2010 11:55 M M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JOHNS HOPICINS BAYNEW MEDICAL CENTER BALTIMORE N/A5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 😾 F 089767777947 218-46-8138 MARYLAND 63 Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 209 S. DURHAM STREET 21231 U.S.A. Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) BOTTLER LIQUOR CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN В. FRAZIER GENEVIEVE R. KENDZIERSKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231 WALTER KUCHTA, JR/HUSBAND S. DURHAM STREET, BALTIMORE, MARYLAND Important: If iten any injury or othe once. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State BAYVIEW CREMATORY: 9/7/10 4 Donation 5 Other (Specify) BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LTLLY & ZEILE 1901 EASTERN ERVINCE, EUNERAL HOME AVENUE, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) ASPIRATION HOURS Medical Due to (or as a consequence of): Examiner ESOPHAGEAL CANCER 5 MONTHS Sequentially list conditions Examiner if any, leading to immediate cause. Enter Uniterlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and or use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate has page 2 Hospital or Attending Physician: The Yes 2 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No မ 1 🛂 Inpatient 2 🗌 ER/Outpatient 3 🗐 DOA 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending Investigation Accident
Suicide 24 hours after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifle 29c. License number 29d. Date signed (Month, Day, Year) NES-000 september 4 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST #401 BALTIMORE mp 21201 RANA FARHADI 39 WEST VEXINGFION

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 27808 1. For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Medical Examiner Justin T. Kent 1600 hrs September 2, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Deat Franklin Square Hospital Rosedale **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Director 150-80-2483 Hours Min 1 X M 2 F 23 Sept. 30, 1986 Country) NJ Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore or 28a-f show Middle River 1 Yes 2 X No hours after death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 114 Yawmeter Drive 21220 USA 23a Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. items must be 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 X Never Married White etc. 2 Married Yes 10 Specify: White 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 X No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be fifled within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n
injury or other traumatic event, the Medical F. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 11th Constrution A&L incrop. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be JAmes Kent Christina Williamson ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James <u>Kent</u> 114 Yawmeter Drive Baltimore MD 21220 /father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
Bayview Crematory 1 Burial 2 Cremation 3 Removal from State 9/7/10 Baltimore MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex **Physician** 23a. Part I. Enter the disease, or complications that caused Me death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Combined toxicity of methadone and cocaine Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, the attending physician and for use as the burial -X UNPENDED 28a-f, per ME g908 10/21/10 TT the Hospital or Attending Physician: The law requires that the death certificate be Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate Yes 2 No 1 🗸 Yes 2 No Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this ٩ 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural neral Director: , y filled in by the f Pending 1 Yes 2 X No hours after death. Fd 9/2/2010 Fd 3:20 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 114 Yawmeter Liddle River, MD 3 Suicide 6 X Could not be within 24 hours a To the Funeral 1 determined (Specify) Found: residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 3, 2010 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) SFP 0 7 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1 Per Phy G907 9/07/10 IH
State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM#4c, perPHYS, 10b, e. perFH, G909, 11/23/29 10, W5

Certificate of Death

Reg. NZ. 10 Perpendicular 1 - For State Registrar Decedent's Name (First, Middle, Last)
 Adolph 2. Date of Death Day 2010 Physician/ Adolf Anthony Krizek 5 P M Sept Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death
Tince George
Montgomery **Examiner** Renaissance Gardens Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min May 10 XX M 2 D F 97 Maryland Director 1913 216**-**03-6999 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Prince George's 1 Yes XXNo Silver Spring ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20904 3160 Gracefield Rd. U.S.A. #T2120 death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Mental Hygiene. þ 72 hours after Baltimore, Maryland 21215-0036 1 Yes XX No Specify. Specify: White Completed 3 Divorced 4 Divorced Year or Dates the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) Metal Refining Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Owner / Operator Business marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph J. Krizek Rose Sykora and 2 should the Health and Me and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra South Lake Way; Reisterstown, MD 21136 Alice Bafford / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott Date XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other p. Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 9/4/2010 Pikesville, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of by no all Se vice Licensee 11605 Reisterstown Rd. Owings Mills, MD2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician CHF disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner A-Fib Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury transit or Attending Physician: The law requires that the death certificate be executed HTN and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Dementia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? has autopsy performed 2 No Yes 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 3 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After eted filled in by the funera 1. Natural 5 Pending work' М 1 Tes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 📈 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11176 33 30. Name and address of person who completed cause of death item 23a) (Type, Print) 3110 Gracefield Rd. Silver Spring, MD 20904 Julanie Harding 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylar	-	artment of latificate of			1ental Hy	•	2010	2	7810
			Registrar  1. Decedent's Name (First, Middle,	Last)		061	tincate or	Jeaur		2. Date of De	Reg. N	2010		. Time of Death
P	hysicia		<b>El</b> eonora		Kalina					Month Septem	her	3,2010		1:00 A M
1	Medic Examin		4a. Facility Name (if not institution,				4b. City, Town, o	r Location		осресы		c. County of De	ath	1.00 A
			Montgomery Hosp	ice Case	y House		Rockvil	.1e				Montgom	ery	
	uneral rector		219-86-2411	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. I		If Under 1 Year Months Days	If Und Hours	er 24 Hrs. Min,	8. Date of Bi (Month, Da March	rth ay <i>Year)</i> 13,	9. B 1941 R	irthplace ountry) USS1	(State or Foreign
ъ	at.	يا	Usual Residence of Decedent  10a, State 10b. County	1.18	10c Cit	ty, Town or Lo	cation						104	Inside City Limits
arylar	a-f sl fied	ecto												1 Yes 2 X No
he M	or 28 e noti	Ë	MD Montgo:	mery		Silver	10f. Zip Code				10a, C	itizen of What 0		
with	s 23a ust b	Funeral Director	15101 Interlach	en Drive	# 923		20906				US	A		
after death	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Was Dec Armed Fo 1  Yes If Yes, Gi	edent Ever in U.s orces? 2 🛣 No ve	'	Was Decedent of I f Yes, specify Cub I ☐ Yes 2 🔀 No	an, Mexic	an, Puerto	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh Specify: W	ite, etc.	ndian,
215-0036 in 72 hours after e.	natur: ical E	Completed	15. Deceden			16a. Deced	dent's Usual Occu	oation			I 16b	Kind of Busines	s Industr	٧
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with gien	t, the			1		Micr	obiologi	st			]	Researc	h.	
Maryland 2 should be filed th and Mental Hy	ed ot	To Be	17. Father's Name (First, Middle, La Unknown Duc	•					_	e (First, Middle		n Surname)		
II Y I	mark	ľ	19a. Informant's Name/Relationshi	hovny		405 14-111	- 4 /04 4		known	Dinet			7:- 01-	
S sho	27 is trau		Charles R. Kali		ınd	1	ng Address <i>(Street</i> Interla						•	
fe, 1 and f Hea	item		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of		_ I	Date _	1	Location - City of		
Page Pert c	ant: If		1 ☐ Burlal 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (S)		State Mor	remetery, crem itgomer matori	natory`or other pla 'Y um。 Inc.	ce)	Sept 201	oate 7,	Rei	thesda,	Mar	vland
<b>Baltimore,</b> permit. Page 1 and Department of Hea	Important: If its any injury or of once.		21. Signature of Funeral Service Li	cersee	1/65		Name and Addre obert A. 00 West	ess of Fac Pump	ohrey	Funeral				
			23a. Part 1. Enter the disease, or o	complications that	caused the deat								App	proximate
Phys	sician/	8 3	shock, or heart failure. List or Immediate Cause (Final disease or condition	•	acn iine. i—Hodgki	ne I.vm	nhoma						Ons	erval Between set and Death
M	edical		resulting in death)		(or as a conseq		piroma						MOI	nths
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5/60 ficate b	g phy as the	Medi		_ u										
<b>GOX 08</b> e death certifi	the attendin	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live	tcome of pregna Birth 2  Feta gnant at time of a nown	al death 3	Ectopic pregnan Other (specify)	су				23d. Date of d Month	elivery Day	<b>Ye</b> ar
that to the contract of the co	ed by detac	y Ph	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause g	ven in Pa	rt I.	23e. Did	tobacco	use contribute	to the ca	ause of death?
S, I	n sign Id be	d by	Deep Vein Thr	omboses						1 🗆	Yes 2	2 🗆 No 3 🗆	Probably	4 🛚 Unknown
	shou	olete	Atrial Fibril	lation						24a. Was				indings available
VITAI KECOFOS, ysician: The law requires	te has	Completed								perf	opsy ormed? 2 K	death?	es 2 🔀	etion of cause of
an:⊺	rtifica xtor, p	Be C	25. Was case referred to medical examiner?	Company of		946	26. F	ace of De	eath (Check		2421	VO]	es 2 A	INO
VIT hysic	nis ce I direc	10	1 Yes 2 X No	Hospital:	Inpatient 2	ER/Outpatier	ot 3 DOA Oth	er: 4 🗆	Nursing Ho	me 5 🗆 Resi	idence	6 🖾 Other (Spe	ecify)Ho	spice
on of ending Pheath.	or; After ti he funera	Certificate:	27. Manner of Death  1 A Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could n	ation	of injury oth, Day, Year)	28b. Time of injury	wor	yat k? Yes 2		28d. Describe	how inju	iry occurred		
<b>DIVISION</b> tal or Attendin rs after death.											ural Rou	te Number,		
ne Hospi in 24 hou	he Funer pleted fill	Medical	(Check 2 Medical Ex	Physician: To the I caminer: On the ba Nurse Practioner:	sis of examinatio	n and/or invest	tigation, in my opini	on, death	occurred at	the time, date	and plac	e, and due to the	e cause(s	s) and manner stated.
To th	To t		29b. Signature and title of certifier				29c. Licens	e number			29d. D	ate signed (Mor	th, Day,	Year)
			1 46h	en V			D371	42			9-	3-2010		
-			30. Name and address of person w						3.6					
	Stat		G. Coleman 1 31. Date filed (Month, Day, Year)		Piccar Registrar's Signa		e Kockvi	тте,	Mary.	Land 2	2085	U		
F	Stat Registra		SED 0 7 2010	6										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010  $A^{\mathsf{M}}$ 6:20 Ernest John Krug aka E.J. Krug September Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F Months Days Hours Min Illinois 71 February 1, Director 354-30-0584 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director 1 Yes 2X No Bethesda Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20814 United States 7905 Chelton Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Sales Technician Hardware Be Maryland 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ann Hermann permit, Page 1 and 2 should by Department of Health and Mer Important: If item 27 is mark, any injury or other traumatic injury or other traumatic Ernest J. Krug 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7905 Chelton Road, Bethesda, Maryland 20814 Frances Krug / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State September 6 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda. Maryland Crematorium, Inc. Robert A. Pumphrey Funeral Home/Chevy Chase, Inc. |7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Fugeral Service Licen-Haran M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Hodgkin's Non Physician/ disease or condition resulting in death) ymphoma Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 ☑ No 1 🗌 Yes 2 🗆 No certificate 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 1 No Other: 유 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours a ✓ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause (s) and due 29a. Certifier (Check within 2 Certifying Nurse Practioners To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D0066990 3110

Registrar
DHMH 17 Rev 7/2009

State

Vinni Juneja, M.D. 6420 Rockledge Drive #4100, Bethesda, Maryland 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SEP 0 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per Fh g908 10/22/10 TT State of Maryland / Department of Health and Mental Hygiene Amend #8 per 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death onth Physician/ 43 and 2010 015 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2915 W. Cold Spring Lane Baltimore Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 1925 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □X Maryland  $0^{Month_{2}^{Day}}$ 2010 Director 219-10-8616 85 Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No MD N/A Baltimore 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral items 23a 8 Tyler Falls Circle 21209 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🄀 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) unk Presser  $N/\Delta$ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Levern H. Stevens Hattie Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Falls Circle, Baltimore, MD 21209 Regina Brown (Neice) Tvler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crownsville Cem. 09/07/10 Baltimore, MD 22180825Hream Factor Ave., Baltimore, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between On exand Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions. Physician/Medical Examiner Oue to (or as a consequence of) if any teaching to him eccause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) page 2 should be detached Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death LANF Physician/ LUCY 35 PM Sextember 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITal RandallsTown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Day, Ye Social Security Number 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) **Funeral** 1 M 2 🕱 f 217-20-8896 84 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗆 No Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 10 Allspice Court 21117 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucv Karahuta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen M. Moses, Daughter Allspice Court, Owings Mills, Maryland 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 9/5/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Aman a Heaston 22. Name and Address of Facilit Cremation Society of Maryland. Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Veal Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Dld tobacco use contribute to the cause of death? þ fibrillations 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 2 2 No ☐ Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 A No ပ္ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier September, 3, 2010 Loun

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abdallah Kafrouni, 5401, Old Court Road, Randolls Town, HD 21133

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 08 10 PRECIOUS LAMIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES PRINCE GOERGES HOSPITAL CHEVERLY If Under 24 Hrs. 8. Date of Birth (Month, Day, AUG. 20, If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 □ M 21K F Months Days Hours MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Woolcal Exon. In the coulding at 1 ☐ Yes 2X No Director PRINCE GOERGES BRANDYWINE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20613 USA 15413 KENNETT SQUARE WAY by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify If Yes, Give Year or Dates: Specify: BLACK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 721 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F is marked otl Be BEATRICE LAMIN THOMPSON IBIDUN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun QDGE. 20613 15413 KENNETT SQUARE WAY BRANDYWINE, MD BEATRICE LAMIN - MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 9-3-2010 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL FUNERAL HOME OF MARYLAND 4308 SUITLAND RD. SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as car inc or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont Month Day Year 5 Other (specify) 1 Tyes 2 No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **N**o 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2♥No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated.

State

DHMH 17 Rev 1/2001

FOMUFOD

29b. Signature and title of celtifier

32. Registar's Signature

Neona-

3001 Hospital Dr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Cheverly, MD 20785

29d. Date signed (Month, Day, Year)

29

08

1			Please	Type or Print in				•		_	
-			1 - For State Registrar	State of Maryla		partment of <i>ertificate o</i>		Mental Hy	/giene Reg. No	010	27815
	Physici /Medic Examir Funeral Director	cal	018-28-2181	Paul Lo e street and number)	'e	ay) If Under 1 Yea		8. Date of B	Day 4c.	County of Deal	3. Time of Death 5:49 AM th 1more thplace (State or Foreign bunity) Mary lance
	faryland show	'n	Usual Residence of Decedent  10a. State  10b. County		City, Town o	r Location	\ \ \ \		,		10d. Inside City Limits 1 ☐ Yes 2 M No
•	with the Maryla He or 28e-f show Le natified et	Director	100. Street and Number 1819 Laurel F	Imore Lidge Driv	e	10f. Zip Code	21120		10g. Cit	izen of What Co	
9036	within 72 hours after death with the Maryland ene. ene. than "neture!, or liems 23e or 28e-f show the Marical Examiner must be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Co	ıban, Mexican, Puei	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, Whit	nican Indian,
1215-(	d within 72 hours jiene. r than "neturel! The Medical Ex	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(G	ecedent's Usual Occive kind of work dor e. DO NOT use reti	e during most of wa	orking	Gen		lley Outdoor
and 21215-0036	led tygii her	Be	17. Father's Name (First, Middle, Last)	A. LaMo		wner/	18. Mother's Na	me (First, Middle		Perki	Center
Mary	es 1 and 2 should be fi of Health and Mental H filem 27 is marked of r other treumatic ever	To	19a. Informant's Name/Relationship ( Jane La Mor	Type, Print)	19b. M	ailing Address (Stre	et and Number or R	ural Route Numb	irkt	or Town, State, 2	Zip Code) > 21120
Baltimore,	permit. Pages i Department of H Importent: If ite eny injury or ot once.		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif.  21. Signature of Funeral Service Licer	Removal from State	cemetery, cons F	crematory or other p	napel Jep	+3,2010	Fon	est Hill	Manland ces-Monkton
8	8 9 E 8 9		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	- 1		ork Road	1, Mon	Ktor	s, mary	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Arteriosc  Due to (or as a conse		tic Can	iovascul	ar Die	ડુશવડ	e	Onset and Death
	cuted nd ransit	aminer	Sequentially list conditions, any, loading to initial ordinate cause. Enter Underlying Cause (Disease or injury that initiated events	b	quarina orj:						
Box 68760,	icate be exec physician an s the burial-tr	dical Ex	resulting in death) Last	Due to (or as a consect d.	quence of):						
P.O. Box (	Attending Physicien: The law requires that the death certificate be exerdeath.  Jean,  Sctor: After this certificate has been signed by the attending physician are the funeral director, page 2 should be detached for use as the buriat-to	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of 6 9 Unknown	al death	3 □Ectopic pregnar 5 □ Other (specify)				23d. Date of del Month	ivery Day Year
rds, P.	quires that in signed by	by	Part II. Other significant conditions of	ontributing to death but not res	sulting in the	e underlying cause (	given in Part I.		tobacco u	_	the cause of death?
Division of Vital Records,	sicien: The law requir certificate has been s rector, page 2 should	Completed						24a. Wa: auto perf 1 Yes		prior to death?	atopsy findings available completion of cause of
Vit.	sicier certif irecto	o Be	25. Was case referred to medical examiner?  1 ★ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpa	oC PO - C	\thora	ath (Check only		0 TO: 10	
of	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date of Injury	28b. Time	e of 28c. In	ury at	28d. Describe		6 □Other (Spectory occurred	cny)
ion	ttending F death. ctor: After y the funera	atlo	1 X Naturał 5 ☐ Pending 2 ☐ Accident investigation		Injur		ork? ☐Yes 2☐No				
Divis	or of in t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, ify)	street, factory, offic	9	28f. Location City or To			ural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exan	ysician: To the best of my knowning: On the basis of examination and manner stated.	owtedge, de ation and/o	eath occurred at the rinvestigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	To the within.	Mec	29b. Signature and tipe of certifier	sing indiano, stateg.		29c. Lice	nse number		29d. Da	te signed (Monti	h, Day, Year)
	. , , ,		I har pathitte Mo	Deputy		DIS	3667		Sent	ember	2,2010
5+	1		30. Name and address of person who	completed cause of death (Item	m 23a) (Tyr	pe, Print)	71.+6.	011/10	M	1 7100	2 3
	Sta Registr	- 4	31. Date filed (Month, Day, Year) SEP 0 7 2010	completed cause of death (Itel	ature	2	, , cu , rue	io, ne	1	5 210	7.3
			V	1	1						

DHMH 17 Rev 1/2001

10-05476 David Massey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

avid Massey		State of Maryland / De	epartment of Certificate of		Mental H		201	0 27816				
Physici		Decedent's Name (First, Middle,Last)				Date of Dea     Month	Day Year	3. Time of Death				
edical Exam	iner	David Massey  4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Loc	ation of Death	July 22, 2	4c. County of I	1510 hrs Death				
		Southern Maryland Hospital		Clinton			Prince Ge					
Funeral Director			yrs. last birthday) S8 Yrs.		Hours Min.	7		9. Birthplace (State or				
· ·		Usual Residence of Decedent	City, Town or Location					10d. Inside City Limits				
nd thow an	Ļ		Jpper Mai					1 X Yes 2 No				
ne Maryland or 28a-f show any ffed, at once.	Director	10e. Street and Number		10f. Zip Code	2		l Og. Citizen of What	Country?				
rith the state or state or notifie	al Di	9210 Fairhaven Ave  11. Marital Status 12. Was Decedent Ever	in IIS 13 Was	2077:			U.S.A.	American Indian, Black,				
death w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 N	If Ye	es, specify Cuban, Me			White, e	etc.				
rs after ural", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade complete	1	Yes 2 X No sp		work done	Specify: E					
5 72 hou in "nati	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	st of working life. DO	NDT use reti	red)						
-003 I within giene. ther the	dwo	1 2 2 17. Father's Name (First, Middle, Last)	Furi	niture Re			Priva	ice				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens Important of Health and Mental Hygiens Important: If tiem 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	BeC	Collel J Massey Sr		,	Lilli	lan He	nderson					
1D 2's should and Maric commatic commatic command to a support the support to a sup	To	19a. Informant's Name/Relationship (Type, Print)  Collel J. Massey -Brothe	r Upper	Address (Street and Fairhave Marlbo	d Number of F en Ave	Rural Route Nur	mber, City or Town, :	State, Zip Code)				
Baltimore, MD bernit. Pages 1 and 2 sho Department of Health and Important: If item 27 is njury or other traumati		20a. Method of Disposition 2 1 X Burial 2 Cremation 3 Removal from State	Ob. Place of Disposit	ion (Name of cemete		Date	20c. Location - Ci					
ti Page trant o		4 Donation 5 Other Specify:	Heritage		_			•				
Bal permi Depar Impo injur		21. Signature of Funeral Service Licensee	22. Na 201	9 MLK J	r Ave	SE, W	ashingto	neral Home on, DC 20020				
Physician Medical		28a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.	eath. Do not enter the	e mode of dying, such	h as cardiac or	r respiratory arr	est, shock, or heart	Approximate Interval Between Onset and				
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Drowning  Due to (or as a consequence)	ce of):					Death				
	-e	Sequentially list conditions, if any, leading to immediate    b.   Due to (or as a consequent	ce of):									
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated										
be executed ician and urial - transit		events resulting in death) Last Due to (or as a consequent	d.									
10, e be execute ysician and burial - tran	ledical	UNPENDED AMENDED					15.5.4					
Box 68760 death certificate be the attending physical for use as the bu	ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of p	2 Feta	al death 3 E	ctopic pregna	ncy	23d. Date of de Month	Day Year				
Box e death c the atten	Physic	1 Yes 2 No 9 Unknown 9 Unknown	or death 5 Othe	er (Specify)		112122						
ires that the signed by a detache	by Pi	Part II. Other significant conditions contributing to death but n	not resulting in the un	derlying cause given	in Part I.		obacco use contribut	e to the cause of death?  Probably 4 Unknown				
of Vital Records, P.O. ng Physician: The law requires that the three of the this certificate has been signed by neral director, page 2 should be detace	eted					24a. Was	an 24b. Wer	e autopsy findings available				
Reco	Completed					autop perfor 1 <b>V</b> Yes	rm <u>ed</u> ? dea	r to completion of cause of h? Yes 2 No				
Vital Recaysician: The this certificate director, page	Be	25. Was case referred to medical examiner?  [Hospital: 1 Inpatient 2]			Death (Check o	,						
n of Vi ing Phys After this funeral di	<u>د</u>	27 Manner of Death 28a Date of Injury	✓ ER/Outpatient  28b. Time of Inj		Work?	28d. Describe I	Residence 6 0	other:				
sion ttendin death. ctor: A y the fu	atio	1 Natural 5 Pending FOUND: 2 ✓ Accident Investigation  1 Natural 5 Jul 22, 2010	FOUND: 1421 hrs	1 Yes	2 V No	Subject drov	wned					
Division tal or Attendir as after death.  "al Director: A led in by the fu	The street of th											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	중로일 🚾 Casa. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
To the within 2 To the complet	Medi	29b. Signature and title of certifier	on and/or investigation	29c. License nur		trie time, date	29d. Date signed					
			2 1)1	O.C.M.E			July 23, 2010					
3v		30. Name and address of person who completed cause of death (I Russell Alexander MD. Assistant Medical Ex	Item 23a) Kaminer 111 F	Penn Street, Bal	OCA	5 21201						
	ate	31. Date filed (Month, SE, Pa) 7 2010 32. Resistrar's Sign		. AP B								
Regist	rar	01 LUIU CERCUIL	1 St. 186	1500								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** .55 Any 2010 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore ear If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/05/1951 Social Security Number 9. Birthplace (State or Foreign **Funeral** Mississippi 1 M 2 □ F Months Days Hours Min. 49 Director 216-56-7375 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 XYes 2 ☐ No Funeral Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or items any night of other traumatic event, the Marical Examinar must be note. 2107 Lyndhurst U.S.A. Ave. 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Laborer Pritchard-Brown LLC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk ပ Annie Pearl Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Nelson(Fiance) 2107 Lyndhurst Ave., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Mem. Park 09/10/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD <sup>22</sup>Joseph Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 No Month Ye aı ☐ Pregnant at time of death certificate has been signed by the ector, page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2**X** No 2 🗆 No 1 ☐Yes 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed caus death (Item 23a) (Type, Print) OWNSIEL 10

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Regia

10-06621	
Clifton Mye	rs

Please Type or Print in Black Indelible Ink Freure All Copies Are Legible

lifton Myers	State of Maryland / Departm	nent of Health and Mental Hygiene	2010 27818								
DI	Registrar	cate of Death	Reg. No.								
Physician Medical Examine	r Clifton Myers	Month Septen	Day Year 1030 hrs								
	4a. Facility Name (if not institution, give street and number) 820 South Caton Ave Apt 8F	4b. City, Town, or Location of Death  Baltimore	4c. County of Death N / A								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last bit only 1 X M 2 F 52		Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign MD Country)								
Aaryland 28a-f show any 1 at once.	Usual Residence of Decedent   10a. State	n or Location altimore	10d. Inside City Limits 1 X Yes 2 No								
th the Maryland 23a or 28a-f sho notified at once.	· · · · · · · · · · · · · · · · · · ·	10f. Zip Code 21229	10g. Citizen of What Country? USA								
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Filmeral Director	3 Widowod 4 Divorced If Yes Give Year	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No specify:	No- 14. Race - American Indian, Black, Affican Specify: Amer.								
136 hin 72 hours e e. than "natura edical Exami		Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Dusekeeping	16b. Kind of Business/Industry Hospital								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	To be december a Cauchation (Specify only highest grade completed)    15. December's Education (Specify only highest grade completed)   16. December 3 Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)   18. Mother's Name (First, Middle, Maiden Surname)   19. Mailing Address (Street and Number or Rural Route Number, City or Town 25.1 S. Paca St., Balt., MD 2123   19. Mailing Address (Street and Number or Rural Route Number, City or Town 25.1 S. Paca St., Balt., MD 2123   20. Method of Disposition   1										
MD 21 td 2 should alth and Me m 27 is ma summatic ev	Debia villes/Sister	9b. Mailing Address (Street and Number or Rural Route 1 2511 S. Paca St., Balt.	,MD 21230								
Baltimore, permit. Pages 1 an Department of Hea Important: If iter	1 Burial 2 A Cremation 3 Removal from State BatV		20c. Location - City or Town, State Balt., MD								
	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hari P. 5126 Belair Rd, Balt.	,MD 21206-5105								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		arrest, shock, or heart Approximate Interval Between Onset and Death								
ū	or condition resulting in death)  Due to (or as a consequence of):  b.  Due to (or as a consequence of):  b.  Due to (or as a consequence of):										
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
execution and ital and ital		,27-28a-f,perME,G908,10/12	/2010.WS								
Records, P.O. Box 68760, —C The law requires that the death certificate be executed has been signed by the attending physician any page 2 should be detached for use as the burial - trace.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pregnancy 5 Other (Specify)	23d. Date of delivery  Month Day Year								
i, P.O. Be ires that the decision is signed by the about the detached fine by Physical by			d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 V Unknown								
Division of Vital Records, rat or Attending Physician: The law require rs after death.  at Director: After this certificate has been sited in by the funeral director, page 2 should be rification: To Be Completed	24a. Was an autopsy prior deat 1										
Vital Recysician: The list certificate I director, page	25. Was case referred to medical examiner?   Hospital: 1   Inputiont 2   ED/O	26.Place of Death (Check only one)	Residence 6 ✔ Other Scene								
n of V ding Phys h. After thi funeral di	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b.	Time of Injury 28c. Injury at Work? 28d. Describ	e how injury occurred t ingested acetaminophe								
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificonpletely filled in by the funeral director, I ledical Certification: To Be C	2 Accident Investigation 3 X Suicide 6 Could not be determined determined	arm, street, factory, office building, etc. 28f. Location or Town	(Street and Number or Rural Route Number, City, State) 820 South Caton Aver								
To the Hospit within 24 hour To the Funerational Completely fill Medical Ce	1/9a Centiler .										
To wit To con	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 3, 2010								
Oxford	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Pen	n Street, Baltimore, MD 21201									

State Registrar SEP 0 7 2010 DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virginia Lee Morton Medical 4a. Facility Name (if not institution, give street and number, **Examiner** Baltimore Greneral N/A Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days 1<u>947</u> 1 □ M 2 🛱 F Months Hours Month, Day, Maryland Director 214-46-8634 63 Usual Residence of Decedent should be filed within 72 mount and Mental Hygiene.

and Mental Hygiene.

7 is marked other than "natural", or items 23a or 28a-f show marke event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 😡 Yes 2 🗌 No N/A Baltimore Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3925 Maine Avenue 21207 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Š 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: If Yes Give White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher 5+ years Education permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other any injury or other traumatic event, theorem. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Copeland Morton, Jr. Griffith Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3667 Ash Street Baltimore, Maryland Sarah C. Morton (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 9-4-10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 23a. Part 1. Buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transi that initiated events resulting in death) Last to (or as a consequence of attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death Year Yes L Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 25. Was case referred to medical the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ( Icu Resident ) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State

PHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Cert	ificate of L	Death			Reg. No.	.010	27820
1. Decedent's Name (First, Midd Physician/ Bernard John Me							2. Date of De Month Septem		3, 20°1°	3. Time of Death 6:43 PM
Examiner 4a. Facility Name (if not institution 229 Dunkirk Rd	•			4b. City, Town, or Balti	more	of Death		4c. 0	County of Death Baltimor	
Funeral Director  5. Social Security Number 220-09-5923 Usual Residence of Decedent	6. Sex 1 M 2 □ F	ge (In yrs. last 89		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da January	th 7' II', 1	9. Birth Cour Ma	place (State or Foreign ntry) ryland
To a State 10b. Count Maryland Balt:	•	10c. City, T	Town or Loca imore	ation						10d. Inside City Limits 1 ☐ Yes 2 🕅 No
Haryland Balt:  10e. Street and Number 229 Dunkirk Rd  11. Marital Status		J		10f. Zip Code 21212				•	zen of What Cou ced Stat	•
° 2.5 1	If Van Civa	No	lf \	as Decedent of Hi /es, specify Cuba	n, Mexican	i, Puerto R	ify Yes or No- lican, etc.)		14. Race - Americ Black, White, Specify: wh	
Waryland C 21215-0036  Be should be filed within 72 hours after 215 marked of within 72 hours after 32 is marked other than "natural", of Specify only high secondary (0-12)  Be Completed by Michael Barnard John Me 19a. Informant's Name/Relation Nick Medairy/so	lent's Education hest grade completed) College (1-4 or		(Give kir life. DO	nt's Usual Occupa nd of work done o NOT use retired)	ation during most	t of workin	g		nd of Business In	
Tand Merital Hygier All All All All All All All All All Al			<u> </u>	orney		er's Name etta	(First, Middle,	leg		
19a. Informant's Name/Relation				Address (Street & unkirk R			Route Numbe imore,		Town, State, Zip (	Code)
Time training the first of the		. cem	etery, crema Cathed	tion (Name of tory or other plac ral Ceme	ter S	ep. 7		Balt:	•	
John V. M	utchell "		Mi t 650	Name and Addres chell-Wi O York R	edefe d	eld F Balt	uneral	Home MD	Inc. 21212	
Medical Examiner  Sequentially list condition resulting in death)  Sequentially list conditions if any, leading to immediate	a. Congress Due to (or as Due to (or as	e.  A consequent a consequent	ce of):	FAILU					Egurg	Approximate Interval Between Onset and Death
'60 ate be e physiciar the burit	d	2 Fetal de	/ eath 3 □	Ectopic pregnanc	у			23	23d. Date of deliv	ery Day Year
The transfer of the death of th	9 🗆 Unknown			Other (specify)	en in Part I	l.	23e. Did to	obacco use		he cause of death?
Division of Vital Records, P.O. Box 6887  Division of Vital Records, P.O. Box 6887  Within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending process. The funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director, page 2 should be detached for use as to make the funeral director and the detached for use as to make the funeral director and the detached for use as to make the funeral director and the detached for use as to make the funeral director and the detached for use as to make the funeral director and the detached for use as to make the funeral director and the detached for use as to make the funeral director and the detached for use and the detached for use as the detached for use and the detached for use as the detached							24a. Was autop perfor 1 Yes	an psy prmed?	24b. Were auto	psy findings available impletion of cause of
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only one) 3 Certifying 29b. Signature and title of certification of the signature and the signature an	-4	best of my kn	nowledge, de	29c. License	number				signed (Month,	
30. Name and address of person  NICK MELILS	who completed cause of $\frac{1}{235}$		a) (Type, Prir	POAD T	imor	מטונו				
State Registrar  DHMH 17 Rev 7/2009  31. Date filed (Month, Day, Year)  SEP 0	7 2010 32. Registr	ar's Signature		all?						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27821 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2358 2 Date of Death Physician/ Mento Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕦 Months Days Hours Min. APRIL 23 578-58-9928 Director 89 1921WASHINGTON, DC Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 □ No MD PRINCE GEORGES BOWIE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3850 ENFIELD CHASE COURT APT. #203 20716 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. Completed by 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Yes, Give 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetr. Elementary/Seconday (0-12) College (1-4 or 5+)
YEARS DC GOVERNMENT TEACHER'S AIDE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ HOWARD CHOICE INEZ WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAXINE HERNANDEZ/DAUGHTER 219 WILLOW TERRACE STERLING, VA 20164 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METROPOLITÁN CREMATORY9/03/2010 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL S FUNERAL HOME Signature of Funeral Service Licenses 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Immediate Cause (Final set and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): BETE Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the a Id be detached fu Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital Other: မ 1 🗌 Yes 2 1\_hpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending in 24 hours and the Funeral Director: After the Funeral Director of the funeral filled in by the work?
1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one

State Registrar

29b. Signatu

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	State of Maryland / Department of Health and Mental Hygiene  1 - State Reg. No. 20										201	0	27822	)	
	Physicia Medic Examin		1. Decedent's Name (First, Middle, Last)							2. Date of Death 3. Time of Death					
		n/	Wayne Allen Moates							August 24, 2010 11:00PM					
-			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death							4c. County of Death					
	Examin	er	National Institutes of Health Bethesda								Mont	gom	ery		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs							A family Day Manual					
	Director		250-02-9233	<b>⊠</b> M 2 □ F	50	Yrs.	Wollins Days	Tiodis	July 13	, 19	960	Court	" SC		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show all pipe and injury or other traumatic event, the Medical Examiner must be notified at once.	ايا	Usual Residence of Decedent  10a. State 10b. County		10c. City	Town or Lo	cation					10	d. Inside City Limits	_	
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			SC Newberr  10e. Street and Number	У	10f. Zip Code					10g. Cit	izen of What	Count	ry?	_	
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		Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U.S	. 13. )	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto				14. Race - A				
ဖွ			1 Never Married 2 Married	Armed Forces?	1 ☐ Yes 2 █XNo If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No Specify:					te, etc.			
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Maryland			19a. Informant's Name/Relationship (			19b. Mailii	ng Address (Street	and Number or R	ural Route Numbe	r, City or	Town, State	, Zip C	ode)		
Š			Yvonne Farmer -	Mother		3136	Priscil	la St.	Newberry	, SC	2910	08_			
re,			20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □			lace of Dispo	osition (Name of matory or other pla	ce)	Date	20c. L	ocation - City	y or To	vn, State		
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Baltimore,			21. Signature of Funeral Service Licer	isee /		, M	2. Name and Address arshall	ss of Facility S Funera	1 Home						
<u> </u>			4217 9th St. N.W. Washington, DC 20011											_	
			shock, or heart failure. List only	nplications that cause one cause on each lin	ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line.								Approximate Interval Between Onset and Death		
		ı	Immediate Cause (Final disease or condition		onas Sepsis							Onset and Death 3 days	_		
Ч			resulting in death)							20 years					
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	ed	] <u>E</u>	Cause Disease or linjury		Chronic Granulomatous Disease								50 years		
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B0)		sici	in the past 12 months?  1  Yes 2 No	4 Pregnant at time of death 5 Other (specify)							Month Day Year				
P.O.		IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Live Birth 2   Fetal death   5   Other (specify)   Month   Day									e cause of death?				
σ.		þ	CHROMC GRANLOMATOUS DISEASG LIVER DISME 1 Yes 2 No 3 Probably 4 Unknown												
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Ä	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	ပြိ	25. Was case referred to medical	<u> </u>	-		26 F	Place of Death (Ch	1 X Yes	2 L N	lo 1 L	Yes	2 X No	_	
/ita		o Be	examiner?  1  Yes 2 X No	Hospital:  1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Other:  4 🗀 Nursing Home 5 🗀 Residence 6 🗀 Other (Specify)											
Division of Vital Records,		e: 10	27. Manner of Death	28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred											
U.		Certificate:	1 Natural 5 Pending 2 Accident Investigati	on be 290 Place of Injury - At home farm street factory office 291 Location (Street and											
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	the Hospi thin 24 hours the Funer empleted fill	Medical	29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state.											cec	
		ž	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and the of certifier  29c. License number  29d. Date signed (Month, Day, Year)										_		
	5 × × 5 × 5		Signature and the or certifier  April 296. Signature and the or certifier  \$333.2.2												
	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									_			
10	Steven M. Holland 10 Center Drive, Bethesda, Maryland 20892														
	Sta	ite	31. Date filed (Month, Day, Year) 2010 32. Legistrar's Signatury backs												

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death September Physician/ Brown Τ. 20ปี๊ก Merchant 4:20 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Center Social Security Number 9. Birthplace (State or Foreign Country) Africa 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ₺ M 2 🗆 F Months Days Hours Min. Oct. 24, 1944 65 078-50-3550 Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Ellicott Maryland 1 Tyes 2 X No Howard City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı B309 Corporate Funeral Court 21042 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 A No Specify: "natural", 3 Widowed 4 Divorced Specify: Black Completed Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Accountant Accounting Be filed Department of Health and Mental Himportant: If Item 27 is marked oth any injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Tarwah Do Ware 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merchant, Wife Diana 3309 Corporate Court, Ellicott City, Maryland 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 9/3/2010 Amanda Heaston 21. Signature of Funeral Service Licens 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ 0) 2 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ner Due to (or as a consequence or): Examil the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death ate has been signed by the page 2 should be detached Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 \( \bigcap \)No 3 \( \Bigcap \) Probably 4 \( \Bigcap \) Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signaty re and title of certifier 29d. Date signed (Month, Day, Year) cute J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Cherle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05/ Margaret Marie McCann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3K Ele Funeral If Under 1 Year 8. Date of Birth (Month, Day, Yea Oct. 6, 9. Birthplace (State or Foreig 1 □ M 2 🗓 F Months Hours Min. Director 189-18-3052 87 Yrs Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 W. Ordanance Road Apt. 403 21061 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXNo
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", 3 ☐ Widowed 4x Divorced Specify: Year or Dates White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) vr <u>Secretary/Admin. Assistant</u> <u>Engineering</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Theodore Morris Helen Fitzgerald Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph J. McCann / Son 9806 Wilkerson Road Milford, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park | 09/08/2010 Elkridge, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & CremationM01121 <u>Services PA:</u> 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year the g 🗌 Unknown Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28a 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 🔲 Yes 2 🗆 No Accident Investigation within 24 hours after death

To the Funeral Director: A Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State Registrar

only one

30. Name and address of person

31. Date filed (Month, Day, Year)

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Registrar's

29d. Date signed (Month, Day, Year)

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Dec. dent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Medical Facility Name (if not institution, give street a Examiner City, Town, or Location of Death County of Death len DURNIE Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birth place (State or Foreign Country) Sex. 1 M M 2 □ F Months Days Hours Min. (Month, Day, Director 205-24-0142 Usual Residence of Decedent show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 28a-f 1 🗆 Yes 2 🏝 No Anne Arundel Maryland Millersville 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21108 8049 Veterans Hwy, United States , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 2 X No 1 Never Married 2 Married Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Food Service Director Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James McCallister Maryellen Brennan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henrietta LaPier / Companion 502 Glenview Ave., Glen Burnie, Maryland 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Surial 2 Gromation 3 Removal from State Sept 10<sup>8</sup>, St. Mary's Cemetery 4 Donation 5 D Other (Specify) Homestead, PA 21. Signat 22. Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy., Funeral Home, P.A. S.E., Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ MAC disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying signed by the attending physician and Idea be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? After this certificate 2 1 No Yes 2 10 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 1 Yes 2  $\square$  No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, 4 - Homicide within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 317 AMOILE MSmir Com MCDian

MDHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Director  219-28-8767  1 M 2 F 78 Yrs. Months Days Hours Min. (Month, Day, Year)  August 24, 1932 Ba	he County chplace (State or Foreign untry)  1 Limore, MD.  10d. Inside City Limits  1  Yes 2 No
4a. Facility Name (if not institution, give street and number)  Gilchrist Hospice Center  4b. City, Town, or Location of Death  Towson  4c. County of Death  Baltimore  Towson  5. Social Security Number 219–28–8767  1 M 2 F 7. Age (In yrs. last birthday) 1 M 2 F 78 Yrs.  Towson  4c. County of Death  Baltimore  August 24, 1932  Baltimore  August 24, 1932  Baltimore  Towson  4c. County of Death  Baltimore  August 24, 1932  Baltimore  Towson  August 24, 1932  Baltimore  Towson  4c. County of Death  Baltimore  August 24, 1932  Baltimore  Towson  August 24, 1932	he County chplace (State or Foreign untry)  1 Limore, MD.  10d. Inside City Limits  1  Yes 2 No
Gilchrist Hospice Center  Funeral Director  S. Social Security Number 219-28-8767  S. Social Security Number 219-28-8767  Gilchrist Hospice Center  Towson  S. Social Security Number 219-28-8767  Gilchrist Hospice Center  Towson  S. Social Security Number 219-28-8767  Gilchrist Hospice Center  Towson  S. Date of Birth (Month, Day, Year) August 24, 1932  Ba.  Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimore  County  Monkton  10c. City, Town or Location  Monkton  10e. Street and Number 10e. Street and Number 11ob. County  Monkton  11ob. Zip Code  11ob. Zip Code  11ob. Citizen of What County  Monkton  11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  If Yes, specify Cuban Mexican Puerto Rican etc.)  14. Race - Armed Forces?	e County  Inplace (State or Foreign untry)  Itimore, MD.  10d. Inside City Limits  1  Yes 2 No
Director 219–28–8767 1 M 2 F 78 Yrs. Months Days Hours Min. (Month, Day, Year) Co. August 24, 1932 Ba	10d. Inside City Limits 1 🗆 Yes 2 🗷 No
Usual Residence of Decedent  10a. State    Top	1 ☐ Yes 2 🛣 No
Maryland Baltimore County Monkton  10e. Street and Number 16901 York Road  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  Armed Forces?  14. Race - Armed Forces?  15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes specify Cuban Marican Puerto Rican etc.)  14. Race - Armed Forces?	
10e. Street and Number 10f. Zip Code 10g. Citizen of What Co United State 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - Armed Forces? 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes specify Cultan Marican Puerto Rigan etc.) 14. Race - Armed Forces?	
12. Was Decedent Ever in U.S.  Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
The specify Cuban, Mexican, Puerto Fican, etc.)  Nover Married 2  Married 1  Sec.)  Nover Married 2  Married 1  Sec.)  Nover Married 2  Married 1  Sec.)	
1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Specify:	White
Specify:    Specify:	Industry
Elementary/Seconday (0-12) College (1-4 or 5+)  NA  Supervisor  Black & Dec	der
2 全 変 を	
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip  Mrs. Tammy M. Taylor (Daughter)  P.O. Box 208 Efland, North Carolina	27243
20a. Method of Disposition  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  3 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20c. Location - City or cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)  Call of the place of Disposition (Name of cemetery, crematory or other place)	e Co.)
21. Signature of Funeral Service-Licensee Jeffrey L. Gair, Sr. Parent Address of Facility Peaceful Alternatives Funeral & Cremettion Cent 2325 York Road Timonium, Maryland 2105	
23a. Part 1. Enlier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  Medical resulting in death)  a	Approximate Interval Between Onset and Death
Medical resulting in death)  a. Due to (or as a consequence of):	
Sequentially list conditions, 12 y, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
per	
ng physician of as the buristian of as the buristian of the control of the contro	
Expression of the contribution of the contribu	ivery Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to	the cause of death?
88	robably 4 🗌 Unknown
24a. Was an autopsy performed?  1 Yes 2 No 3 Pr  24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No 1 Yes Prior to compared to the second test of the second test	topsy findings available completion of cause of
25. Vias case referred to medical examiner?  1	
Part   Percentage   Percentag	ity Maspig
28a. Date of injury work?  1 Natural 5   Pending Investigation 3   Suicide 4   Homicide   Accident 3   Suicide 4   Homicide 3   Suicide 4   Homicide 3   Suicide 4   Homicide 3   Suicide 4   Homicide 3   Suicide	ral Route Number,
The second secon	ause(s) and manner stated.
Sentem ()5830) Sentem	GV 4 ZQV
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AAAVA A (AHAAAF) W G 700 A) Charles ST TWS: N M	
State 31. Date filed (Month, Der), Year) 32. Registrar's Signature	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Myrtle Alerthia Miller Month 2010 31". August 4:35 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore County Oak Crest Care Center Parkville 5. Social Security Number If Under 1 If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 21 Months 218-16-0937 86 Bel Air, MD. Director 1924 Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10b. County with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Co. Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 United States 8834 Walther Blvd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married "natural", or Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: If Yes, Give Year or Dates 3 ☐Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Secretary ACME Market Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked August Andrew Beyer Alerthia Luray Sims 19a. Informant's Name/Relationship (Type, Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shi Department of Health an Important: If item 27 is any injury or other trau Mr. Charles William Miller, Jr. 33 Wally Court Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State (Baltimore Co.) Sept. 03, 2010 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gard. Timonium, Maryland Jeffrey L. Peaceful Alternatives Funeral & Cremation Center, P.A.

Timonium. Marvland 21093-2215 Mr. L(Lic. #M00677) Timonium, Maryland Part It. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 12 days Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown the 9 Unknown signed by Part II. Other significant conditions contributing, to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ribrillation 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed per tension. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Ves 2 death? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 No after death Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Manth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) her Blvd. Batto-88 32. Registrar's State Registrar

Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nina A. Mishin September 05,2010 2:55 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Stella Maris Hospice Timonium Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 🗆 M 2 🔀 F Months Days Hours Min. June 09, 1940 229-73-9549 Buzuluk, Russia 70 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Yes 2 No Maryland Baltimore Co. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 23a Funeral 5906 Park Heights Ave. Apt. 507 21215 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify. White Specify: 3<sup>™</sup> Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 05 Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental F marked o per it. Page 1 and 2 should re f Der artment of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Afanasiy Vasilyevich Mariya Pavlovna Shilova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, MD. 21234 Mr. Vadim Shilov 2297 Lowell Ridge Road Apt.A 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland National Cent. 2010 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee Jeffrey I. Gair, Sr. Percential Afternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 (Lic. #M00677) Pa 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Be မြ

Vital Records, P.O. Division of Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the

completed filled in by

Medical

NINA MISHIN

a.m.

Maryland

Baltimore,

ပ္ပ			1  Yes 2 No 1 Yes 2 No
Be (	25. Was case referred to medical	26. Place of Death (Che	eck only one)
인 E	examiner? 1  Yes 2  No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing I	Home 5 ☐ Residence 6 🛣 Other (Specify) HOSPICE
tificate:	27. Manner of Death  1 🛣 Natural 5 🗆 Pending 2 🔲 Accident Investigation		28d. Describe how injury occurred
Certií	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homic		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)	2 Medical Examine		ate and place, and due to the cause(s) and manner as stated. death occurred at the time, date and place, and due to the cause(s) and manner statime, date and place, and due to the cause(s) and manner as stated.

29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State

32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month D.+ Zear 0 1:05 PM Physician/ William L. McClaskey Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** N/A Baltimore Union Memorial Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month, Day, Yebruary 1 XX M 2 □ F Marvland 63 1947 214-46-9900 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1XXYes 2 □ No Maryland N/A **Baltimore** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21217 1806 Eutaw Place Apt A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. ò 1 Never Married 2 Married 1 Yes 2 XX No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Self-employed Residential Cleaning 5+ permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie Mae Herman ٥ Ernest McClaskey 19b. Mailing Address (Street and Number or Flural Royte Number, City or Town, State, Zip Code) 185 South Wood Road, Pasadena, MD 21122 19a. Informant's Name/Relationship (Type, Print) Nephew David McClaskev 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Fullerton, MD 9/11/2010 Signatur 22. Name and Address of Facility Funeral Service Lic Burgee Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Hemorrha9 Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Respirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner (an le signed by the attending physician and be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) 1ears AIDS Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 perform death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 - Yes Certificate: To completed filled in by the funeral Manner of Death Date of injury (Month, Day, Year) 28b. Time of 288 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate

Registrar

Medical

29a. Certifier

(Check

only one

29b. Signature and title of certifie

Memorial HosDital SEP 0 7 2010 32. Registrar's Signature Jark

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

201 E

29d. Date signed (Month, Day, Year)

Parkway

		-	For State	State of Ma	arylan		artmeni <i>tificate</i>			and M	lental Hy		ZUIII	27830	)
			Registrar  1. Decedent's Name (First, Middle, Last)			Cer	lincale	; UI D	eatti		2. Date of De	Reg. No	<u>,                                     </u>	3. Time of Death	_
	Physicia			Carolyn	S.	McWil:	liams				Month Sept	Da 1	y Year 2010	0 0 7 7 14	
~	Medic Examin		4a. Facility Name (if not institution, give str	eet and number)			4b. City, 1		Location	of Death	- 000		. County of Deal		_
لميس			Gilchrist Nursi	~				Tows						more Co.	_
	Funeral Director		5. Social Security Number 6. Sex 1214-44-5908	M 2 🔀 F		nst birthday) Yrs.	If Under Months	1 Year Days	Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da	v. Year)	Co	thplace (State or Foreign untry)	
	N.		Usual Residence of Decedent		65						March	13,	1941 M	aryland	_
	f shoved at	ţţ	10a. State 10b. County		10c. City	y, Town or Lo	cation	n - 1		0.1	h			10d. Inside City Limits	
	Many 28a- notifie	Director	MD N/A		1		1401.7		Limo	re Ci	Т			13€ Yes 2 No	
	ith the		10e. Street and Number	1			10f. Zip		1.0			0	tizen of What Co	•	
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	109 Croydon Ro	a.d 2. Was Decedent E	ver in U.S	S. 13. V	Vas Decede	212 ent of His	spanic O	rigin? (Spe	cify Yes or No-		nited Si		_
ဖွ	or it		1 Never Married 2 Married	Armed Forces?	No		f Yes, speci □ Yes 2				Rican, etc.)		Black, White	e, etc.	
8	urs af tural" al Exa	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.						·.			Specify:	White	_
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212	iled within I Hygiene. other thai		Elementary/Seconday (0-12)	College (1-4 or 5	+)	ŀ	ıker	1011104)					Banking	3	
bu	filed al Hy d oth		17. Father's Name (First, Middle, Last)	_					18. Mot		(First, Middle,		Surname)		
ylaı	should be file and Mental P 7 is marked o raumatic eve	잍	Elmer R. Schick								McClal.				_
Maryland 21215-0036	2 shouth and the and the strain traum		19a. Informant's Name/Relationship (Type										r Town, State, Zi		
	_ =		Mr. Scott McWilli 20a. Method of Disposition	ams (Son)	20b. P	lace of Dispo		ne of			Date		aryland .ocation - City or	21212 Town, State	_
ШŌ	Page 1 nent of ant; If i		1X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		emetery, cren k Lawr				9/4/	2010	Ва	altimor	e, Maryland	
Baltimore,	permit. Page 1 and Department of Hee Important; If item any injury or othe		21. Signature of Funeral Service Licensee			D1	2. Name and 1da – Ri 7922	d Addres UC k Wise	s of Faci Fune	ral H	Home of	Dun	dalk, I 21222	nc.	
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D	nysician/		Immediate Cause (Final disease or condition	Glic	e :	Star	no							Onset and Death	
-	Medical Examiner		resulting in death)	Due to (or as a	consequ	uence of):									
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	ath certificate be executed attending physician and for use as the burial-transit	Ë	that initiated events c resulting in death) Last	Due to (or as a	consequ	uence of):									
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687	rtifica ling ph e as th	/Me	IF FEMALE:	c. If yes, outcome	of pregna	nev.									
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. B	that the dea led by the a detached f	hysi	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	g 🗌 Unknown											_
P.0	ss that tigned b	by P	Part II. Other significant conditions con-	ributing to death b	ut not res	ulting in the u	ınderlying o	cause giv	en in Par	t I.	23e. Did t	tobacco i	use contribute to	the cause of death?	
ds,	requires t been sign should be	ted									1 🗆	Yes 2	!	robably 4 🛴 Unknown	1
of Vital Records,	has be ge 2 sho	Completed									24a. Was	psy		topsy findings available completion of cause of	
æ	ate ha										1 🗌 Yes	ormed? 2 XN		s 2 🗆 No	_
ita	ysician: The is certificate director, pag	Be c	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:		EB/0 1 - 1	0 🗆 🗖	Othe		ath (Check			o MT ou 10	In projected	_
of V	ding Phys th. After this funeral di	e: 10	27. Manner of Death	28a. Date of inju	ry	28b. Time of		8c. Injury	/ at		me 5 ∟ Resi 28d. Describe		6 🔯 Other (Spec ry occurred	HO SO	_
nc	ttending death. stor: After y the funer	icat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day	r, Year)	injury	М	work	? Yes 2[	□No					
Division	or Atter fter de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc			eet, factory	, office			28f. Location ( City or To			ral Route Number,	
۵	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physic	ian: To the best of	mv know	ledge, death	occured at	the time.	date and	d place, an	d due to the ca	ause(s) ar	nd manner as st	ated.	_
	n 24 h le Fun	Medical		r: On the basis of e	xaminatio	n and/or inves	tigation, in r	my opinio	n, death	occurred at	the time, date	and place	e, and due to the	cause(s) and manner state	ed.
	Vithii Vithii COTK	-	29b. Signature and title of certifier				29c	. License	number			29d. Da	ate signed (Mont	h, Day, Year)	
	)		Life, comp						80 8				1/1/201	0	
	Lov		30. Name and address of person who could be a second address of person address of pe	mpleted cause of d	eath (Item	1 23a) (Type, I	Print)	Anr	K L	2015	5 VIII	an	21204	cent	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa		3	Dev		mer	· M	V :	<u> </u>	1	_
	Registr		SEP 0 7 2010	11											_
DHI	MH 17 Rev 7/2	009	JE: 0 1 2010	Clave	1	Da									

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 27831 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09-02-2010 Physician 7:00 The1ma Rosalie Miller A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Tate Center Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–19–1916 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Min. 1 □ M 2 🖼 F Months Hours 578-03-3979 93 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at 1 □ Yes 2 No Director MD Anne Arundel Severna Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 715 Benfield Road United States 21146 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ∐ Yes 2**X X**No Specify. þ Specify. 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Payroll Clerk State of Maryland and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Tilghman Welby Redmond Rebecca Virginia McElvaney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Rosalie Ann Booker - daughter 3945 Eversholt Street, Clermont, FL. 34711 permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other Once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park | 09-07-2010 | Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign, tu a of Funeral Service Licersee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash Blvd, Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** 01005 uears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): , burialphysician at the burial Box 68760. Physician/Medical attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregna in the past 12 mon 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) Ö the ned 9 Unknown signed by the σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe certificate 2 🗆 No 1 □ Yes 1 ☐ Yes or Attending Physician: this certific ral director, 25. Was case referred to medical examiner? HOSPICO Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (S<sub>1</sub> 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the Mann of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation I hours after death.

uneral Director: A

ely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ture and title of certifier ans Hun Mulersville MI 21108 Type, Print) OV 12 dina 8601 Registrar's Sign State Registrar

		-	For State Registrar		State of	Maryland		artment of H tificate of D		d Mental Hy	/giene Reg. <u>N</u>	<u>2010</u>	27832
	Physicia		1. Decedent's Name (First	t, Middle, Last) NARKO	NITZ.					2. Date of D A Month	eath	ay Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not in:			er)		4b. City, Town, or	Location of D			c. County of Deat	
			NORTHWEST			A // /a	nd birdh doul	RANDAL	LSTOWN	Hre O Date of D	inth	BALTIN	MORE thplace (State or Foreign
	Funeral Director		5. Social Security Number  161-38-3031  Usual Residence of December 1	. 1 5	M 2 □ F /.	Age (In yrs. la:	Yrs.	Months Days		Hrs. 8. Date of B Min. (Month, D 11/28/	ay, Year) 1946	Cos	untry) NY
	and show at	ō		County		10c. City	Town or Lo	cation					10d. Inside City Limits
	Maryla 28a-f	rect	MD B	BALTIMOR	RE		OWING	GS MILLS					1 ☐ Yes 2 🗓 No
	h the la or 2	al Di	10e. Street and Number			_		10f. Zip Code			10g. C	Citizen of What Co	untry?
	ith wit	Funeral Director	10112 CASC		LLS COUT		13 \	Vas Decedent of Hi	117	/ (Specify Yes or No		USA 14. Race - Ame	rican Indian
Maryland 21215-0036	filed within 72 hours after death with the Maryland tal Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 🙀 □	2 ☐ Married	Armed Force 1 X Yes 2 If Yes, Give Year or Date	es? No		f Yes, specify Cubar	Specify:	uerto Rican, etc.)		Black, White	
2-C	2 hour "natu	Completed		Decedent's Edu nly highest grad			16a. Deced	dent's Usual Occupa kind of work done d	ation uring most of	working	16b.	Kind of Business	Industry
121	thin 72 ene. than he Me	Com	Elementary/Seconday	(0-12)	College (1-4	or 5+)		O NOT use retired)  S REPRESE	NTATTV	E	ME	EMORABIL	ГА
Q Z	led wi Hygie other ent, tl	Be	17. Father's Name (First, I	Middle, Last)				J KEL KEEL		Name (First, Middle			
/lan	d be f Wenta arked atic ev	2	JEROME		MAI	RKOWITZ			ANNE			FRIEI	OMAN
Jan.	shoul		19a. Informant's Name/R		•		l .	ng Address (Street a					
	age 1 and 2 should be files int of Health and Mental H it: If item 27 is marked of y or other traumatic ever		JILL MARKO		AUGHTER	20b. Pl		CHARTLEY sition (Name of	DRIVE	, REISTER		Location - City or	21136
Baltimore,	Page 1 ment of tant: If it		1 XBurial 2 Cre 4 Donation 5 D			tate C6	emetery, crer	natory or other plac LOM MEM •		9/02/2010	1	EISTERSTO	
Bait	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral S	Service Lice/se	atta	h		2. Name and Addres 8900 REIS		SOL LEVI WN ROAD,	NSON PIKE	N & BROS	., INC. MD 21208
			23a. Part 1. Enter the dis shock, or heart failu	sease, or compl are. List only one	cations that cau cause on each	used the death	. Do not ente	er the mode of dying	g, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
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	Examiner	er	Sequentially list condition	ns, I	Due to (or	as a consequ	IDEW ence of):	111/4					
	cate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last		Due to (or	as a consequ	ence off:						
	ate be executed ohysician and the burial-transi	edical E	resulting in death) Last	L	200 10 (0)	400110040	ondo oiy.						
3760	ficate g phys	Medi				_							- In
Box 68	e death certifics the attending p thed for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregrin the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ns?		rth 2 Teta nt at time of d	death 3	Ectopic pregnand Other (specify)	у			23d. Date of de Month	livery Day Year
1s, P.O.	requires that the de been signed by the should be detached	δ	Part II. Other significant	conditions cor	ntributing to dea	th but not resu	ulting in the u	underlying cause giv	ren in Part I.				the cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed								per	s an opsy formed?	prior to death?	rtopsy findings available completion of cause of s 2 □ No
ta	ician: certific rector,	Be	25. Was case referred to examiner?  1  Yes 2 No	_ h	lospital;		_	Oth	or.	(Check only one)			
of	ing Phys frer this ineral dii	ate: To	27. Manner of Death	Pending	28a. Date of	patient 2 injury Day, Year)	ER/Outpatie 28b. Time o injury	f 28c. Injury	4 ⊔ Nursi ⁄at ?	ng Home 5 Res			<u>ify)</u>
ivision	or Attendi after death Director: A in by the fi	Certificate:	2 ☐ Accident 3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Investigation Could not be determined		f Injury - At ho , etc. <i>(Specify)</i>		M 1 □	Yes 2 □ No				ral Route Number,
۵	Hospital	Medical	(Check 2 D	Medical Examin	er: On the basis	of examination	and/or inves	occured at the time stigation, in my opinio death occurred at the	n, death occu	rred at the time, date	and place	ce, and due to the	cause(s) and manner stated.
	To the within To the compl	Σ	29b. Signature and title o		A A	the best of my	Milowicago,	29c. License		77		Date signed (Mont	h, Day, Year)
			30. Name and address of	M-HEW	mpleted cause	of death (Item	23a).(Tivnes	Print) D	135	/	Huy	MIST 31	12010
0			DR LAUVA	HALLI		ol Od	ct. K	d. Kana	lalisto	DM MO	2	1133	
	Sta Registr		31. Date filed (Month, Day	y, Year) <b>0 7 2010</b>	2. Reg	gistrar's Signat	ure far	Ked					
_					-		-						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 27833

		1- For State Registrar		Certi	ficate of	Death		R	teg. No.		21000
Physici	an/	Decedent's Name (First, Middle, I	Last)					2. Date of Dea	ath	_	3. Time of Death
/ledical Exami		LUTHER NI	LXON					Month August 29	Day Yea 9, 2010	ır	0827 hrs
1		4a. Facility Name (if not institution,			4	b. City, Town, o	r Location of De		4c. County of	of Death	
		2811 Nicholson #101				Hyattsville			Prince G	eorge	e's
Funeral	П	Social Security Number 6.	. Sex 7. Ag	e (In yrs. last	t birthday)	if Under 1 Ye		Hrs. 8. Date of Bi	rth(MM/DD/YYYY	9. Birt	thplace (State or
Director		578-66-2966	X M 2 F		58 Yrs.	Months Day	ys Hours I	02/14	/1052	Foreig	thplace (State or nWASHINGTON untry)D.C.
		Usual Residence of Decedent	ZC W Z 1		JU 113.			02/14	11752		
á		10a. State 10b. County		10c, City, To	own or Location	าก	_				10d. Inside City Limits
DW B			GEORGES		SVILLE						1 X Yes 2 No
Maryland 28a-f show any 1 at once.	ξ		OLOROLD		DVILLE						
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number				10f. Zip Code		1	log. Citizen of Wh	iat Coun	ntry?
the Sa or		2811 NICHOLSON	STREET APT	#101		20785			USA		
with ns 2.7	Funeral	11. Marital Status	12. Was Decedent					Specify Yes or No			can Indian, Black,
jeath r iter	ū	1 Never Married 2 Marri	ied Armed Forces?	- X1	If Ye	s, specify Cuba	n, Mexican, Pue	erto Rican, etc.)	White	, etc.	
fter ( l", o		3 Widowed 4 Divorce	ced If Yes, Give Year or Dates:		1	Yes 2 X No	specify:		Specify:	BLAC	CK
ours a ntura	d by	15. Decedent's Education (Specify		npleted) 1			ition (Give kind		16b. Kind of Bu	siness/Ir	ndustry
72 hc	ompleted	Elementary/Secondary (0-12)	College (1-4 or	5+)	during mo	st of working life	e. DO NOT use	retired)			
336 thin 7. than edical	ldu	12TH			YOUTH	COUNSEL	OR		PRIVAT	E	
od wi	Cor	17. Father's Name (First, Middle, La	ast)				18.Mother's Na	me (First, Middle,	Maiden Surname)	)	
e file tal H ked o	Be (	ALLEN NIXON					QUEEN	DAVIS			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To E	19a. Informant's Name/Relationship	(Type, Print)	-	19b. Mailing	Address (Stre		or Rural Route Nui	mber, City or Town	n, State,	Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shr traumatic event, the Medical Examiner must be notified at once	_	BRENDA THOMAS/FR	RIEND		3818 W	STREET	S.E. U	NIT A WA	SHINGTON	, DC	20020
and and tealth tem		20a. Method of Disposition				ion (Name of ce		Date	20c, Location -		
of H		1 Burial 2 Cremation	3 Removal from Sta	110	matory or other			1001000	l		
Pag Pag tant:		4 Donation 5 Other Spec		Metr	-			/03/2010			
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med	- 1	21. Signature of Funeral Service Lic	ensee					ARSHALL			
TT 8' C' 'E' 'E	_ <u>//</u>	MUAN FROM	Journ 1					D SUITLA			)
Physician		23a. Part I. Enter the disease, or co failure. List only one cause on		the death. D	o not enter the	e mode of dying	, such as cardia	c or respiratory arr	est, shock, or hea	art	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	a Hyperten	sive (	Cardiov	ascular	Diseas	e			Death
Examilier		or condition resulting in death)	Due to (or as a conse	equence of);							
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	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):							
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cuted ind transit	Exa	events resulting in death) Last	d.	, quo 1100 01).							
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760, cate be ex physiciar the burial	/Medical					0					
	Š	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcon	ne of pregnar	ncy	donth 3	Ectopic prec	nancy	23d. Date of Month		
OX 68 eath certif	sician	past 12 months?	4 Pregnant at		=	er (Specify)		grianoy	Monar		ay Year
Box 68 e death certifi the attending ed for use as I	ysi	1 Yes 2 No 9 Unkno			○ □ D##	el (apealy)					
D. B. t the de by the ached f	Phy	Part II. Other significant condition	s contributing to death	but not resu	ılting in the un	derlying cause	given in Part I.	23e. Did to	obacco use contri	bute to t	he cause of death?
, P.O. res that the signed by be detach	ð	Cocaine Use,	Diabetes Me	11itus	5			1 Yes	s 2 No 3	Proba	ably 4 🗸 Unknown
duire auld b	Completed				-			– 24a. Was	an i 24b. V	Vere aut	opsy findings available
COFC law re has be	릛	· · · · · · · · · · · · · · · · · · ·						autop	sy p		ompletion of cause of
Rec The L	E							1 Yes		Yes	s 2 No
tal Recian: The	Bec	25. Was case referred to medical				26.Place	e of Death (Chec	ck only one)			
Vit;	F B	examiner?	Hospital: 1 Inpatie	nt 2 🔙 EF	R/Outpatient	3 DOA	Other <sub>4</sub> Nur	sing Home 5	Residence 6	Other:	Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	틝	27. Manner of Death	28a. Date of Inju (Month, Day, Y	ry 28	Bb. Time of Inj	ury 28c. Inju	ry at Work?	28d. Describe	how injury occurre	∍d	
ion of tending Pheath.	Certification:	1 X Natural 5 Pending	9	501)		1	Yes 2 No				
isi recte	ig	2 Accident Investig 3 Suicide 6 Could n	28e Place of Ini	ury - At home	e, farm, street,	factory, office t	ouilding, etc.	28f. Location (	Street and Numbe	r or Rur	al Route Number, City
Divis pital or At ours after d neral Direct filled in by	핓	3 Suicide 6 Could n  4 Homicide						or Town, S	State)		
Tospi 4 hou uner		29a. Certifier	sician: To the best of my	knowledge	death occurre	ad at the time d	ate and place a	and due to the caus	ea(s) and manner	as stata	d
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	(Official of the	ner: On the basis of exar								
To To	Med	29b. Signature and title of certifier	and manner stated.			29c. Licens	se number		29d. Date signe	ed (Mon	th. Day Yearl
		( M).				0.C.			August 30,	-	, , ,
		00-	<u> </u>						/ 109031 00,		
		30. Name and address of person wh			-	Dans 01 1	Daltina	MD 04004			
10		Donna M. Vincenti, MD	Assistant Medic				, Baltimore,	IVID 21201			
	ate	31. Date filed (Month, Day, Year) SFP 0 7 2010	32. Registrar	s Signature	backer	,					
Regist	اللتالة	SET U ( ZUIU	Colored	No. 169	- 90 61						

			for State Registrar	State of Ivial		ertificate of	Death		eg. No. 2	27834
	Physicia	an	1. Decedent's Name (First, Middle, La					Date of Deat Month	h Day Year	3. Time of Death
-	/Medic		Robert I.			T # 01 T	1 1 1 1 1 1 1	Month 8	Day Year	
	Examin	er	4a. Facility Name (If not institution, giv		1	ROSCO	or Location of Death		4c. County of Deat	nore
	Funeral		Franklin Square  5. Social Security Number 6.5	Bex 7. Age (	(In yrs. last birthday	If Under 1 Year		8. Date of Birth		hplace (State or Foreign untry)
	Director		220-36-9470	<b>X</b> M 2□ F	70 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March3	3,1940	MD MD
	and w		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Inside City Limits
	Maryli -f sho	tor	MD Balti			dle Rive	er			1 □Yes 2 🔀 No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	23a c	ral	631 Hunting	Fields Ro			220		USA	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Ever, and coust be recitified at	by Funeral Director	11. Marital Status  **M Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Eve Armed Forces? X Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of If Yes, specify Cult 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spe pan, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
5-0	72 hc "natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece (Give	edent's Usual Occu kind of work done	pation during most of working d)	ng	16b. Kind of Business/	Dynamics
121	within iene. than	duic	Elementary/Secondary (0-12)	College (1-4or 5+)			Analyst		Generar	Dynamics
	filed Hygi other ent, t	Be Co	12th 17. Father's Name (First, Middle, Last,	)			18. Mother's Name	(First, Middle, M	Maiden Surname)	·
/lan	Jenta Jenta rked ric ev	To B	Frank A. Osb	urne			Mary	J. Whi	ite	
Maryland	2 should be filed w n and Mental Hygie Is marked other ti raumatic event, In		19a. Informant's Name/Relationship (		1				, City or Town, State,	
	t and 2 Health em 27 I		Lavona E. Cil	ento /sis					Perry Hal	
Baltimore,	L i i e Ba		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	(y)		wn Ceme	tery 9/3/		Baltimor	
Ball	er nit. Perartr Importa ny inju		21. Signatur of inneral Service Licer  23a. Partif. Enter the disease, or conshock, or heart failure. List only			22. Name and Addr		00 Mace	e Ave. Ba	lto. MD x 21221
			23a. Parti. Enter the disease, or conshock, or heart failure. List only	plications that caused the	ne death. Do not er	nter the mode of dy	ing, such as cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death)	· Cardi	ac A	rrest				
-	/Medical Examiner		resulting in death)	Due to (or as a o	consequence of):	6	stem	C /.	202	
		Jer	Securifiany list our dilicristif any, leading to immediate	b. Due to (or as a c	consequence of):	)ab 2)	1314111	FOILLA	76	
	acuted nd rransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· Seos	i5					
60,	icate be executed physician and the burial-transit	E	resulting in death) Last	Due to (pr as a c	consequence of):					
68760,	rtificate be executed og physician and as the burial-transit	ledical		_ d						
. Box	ath ce attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 I 4 ☐ Pregnant at til 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnar ☐ Other (specify)	ncy		23d. Date of de Month	livery Day Year
, P.O	that the dended by the detached		Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause g	iven in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
Vital Records,	quires en sign ufd be	ed by						1 □ Y€	es 2 No 3 P	robably 40 Unknown
ဝ၁ဓ	e law requir has been si e 2 should l	Completed						24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
Œ.	siclan: The la certificate ha rector, page	Som						perforr	med?   death?	2 □ No
/ita	siclan: certific rector,	Be (	25. Was case referred to medical examiner?	I the state of		10	26. Place of Death	(Check only on	ne)	
of	D 0 2. ∠		1 ☐ Yes 2 No 27. Manner of Death	Hospital: 11 Inpatient 28a. Date of Injury	2 ER/Outpatie	ent 3 🗆 DOA			ence 6 Other (Spe	ecify)
O	ng ffer iner	tion	Natural 5 Pending 2 Accident investigation	(Month, Day, )	Year) Injury	Wo	ork? □Yes 2 □No	zou. Describe no	ow injury occurred	
Division	l or Attending after death. Director: Afte I in by the fune	Certification: To	3 Suicide 6 Could not b 4 Homicide determined	e 290 Place of Injury	/ - At home, farm, si (Specify)			28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		hysician: To the best of eminer: On the basis of eminer state	xamination and/or i					
	To the within 2 To the comple	Me	29b. Signature and the of certifier	and manner state		29c. Licer	nse number	2	29d. Date signed (Mon	th, Day, Year)
			· ak			Ros	0000	<	8-30-	2010
		ı	30. Name and address of person who							,
j			Dr. John Rom	sang good	ofrant/	n Square	Drive Bo	Utimore	2, MD 2	1337
	Sta Registr		31. Date filed SEP Day, Year 2010	2. Registrar's	s signature	New?				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2010 4c. County of Death N/A Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1X□Yes 2□No 10g. Citizen of What Country? USA Race - American Indian, Black, White, etc. Specify. WHITE 16b. Kind of Business/Industry CLOTHING 18. Mother's Name (First, Middle, Maiden Surname) LAMPE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3041 FALLSTAFF ROAD, #603, BALTIMORE, MD 21209 20c. Location - City or Town, State BALTIMORE, MD SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Approximate Interval Between Onset and Death dAI 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Ønknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ You 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL of BALLMORE BURKE SIR MO SINAT 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 7 2010 Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ OE SEPTEMBER 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** ICHERSGILL ALTIMOR TIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mallont 1.4ay, 19915 Hours 1 □ M 2 🕅 F Min. 95 Maryland 212-30-0706 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 ☐ Yes 2 X No Baltimore County Towson Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21204 Funeral 615 Chestnut Avenue permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Residence Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillie May Hatton ပ Harry Jackson Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Barnold, Daughter 101 Kenilworth Park Drive, 2D, Towson, MD 21204 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition cemeters, crematory or other place)

Green Mount Crematory 9/7/2010 1 

Burial 2 

Cremation 3 

Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign/re 1 Fy ra Syled Torsay Martin U. Lawson MINCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END SPAGE DE MENTA unknown Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) s been signed by the standard should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown FAILURE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an DEBILITY his certificate has b I director, page 2 sh autopsy death? 2 🗌 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 2**X**No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) မ within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral dir 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1XNatural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my onlinon, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier ,0 R079544 02-2010 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 31, Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Physician/ 2010 22:00p.m. Strelsa C. Payne Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A altimore tea If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number (Month, Day, **Funeral** Year 951 Days 1 □ M 2 🛛 F 212-60-9840 58 Yrs. Nov Mary Land Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State **Funeral Director** Yes 2 No Maryland N/A Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5213 Hillwell Road 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Black Specify: 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Dccupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Post Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Alphonso Gorham Strelsa Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Precious M. Payne, Daughter <u>5213 Hillwell Road Baltimore.</u> Marvland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 09/07/10 Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Thomas Gregor 2. Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 roman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between HYPERCARBIC RESTIRATORY FAILURE Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ACUTE Medical Due to (or as a consequence of) Examiner 10 years BRONCHIECTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) OBSTRUCTIVE PULMONARY 42015 Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Dther (specify) Month Year Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown ENDSTAGE RENAL DISEASE, DIALYSIS DEPENDENT Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? eral Director. After this certificate I filled in by the funeral director, page 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatore and title of certific 29c. License number 29d. Date signed (Month, Day, Year) w D2264 SOFTEMBER 4, 2010

Registrar

★ DHMH 17 Rev 7/2009

State

900 SOUTH CATEN AVENUE

BALTIMORE MARYLAND

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

m.D

SNYDER

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 1,24a per doc 8907 9-14-10 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death Dennis R. Patrick Sr. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ September **9** M 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 6 len Burnie Baltimore Washington Medical Cente If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign PA Country) 7. Age (In yrs. last birthday) **Funeral** Months Days (Month, Day, 1X□ M 2 □ F 69 1941 Director 195-32-2793 May Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 XNo Maryland Anne Arundel

10e. Street and Number Glen Burnie 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21061 5825 Ritchie Street hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 2 No 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: 3 Widowed 4 Divorced White Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Department of Defense Administrative Tech Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ permit. Page 1 and 2 should be: Department of Health and Ments Important: If item 27 is marked Jeannette A. Jones George R. Patrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) atrick, 5825 Ritchie Street Glen Burnie, MD 21061 Mrs. Donna M Patrick/ Wife any injury or other 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept<sup>Date</sup> 5 Elkridge, MD 2010 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park 22. Name and Address of Facility Singleton Funeral & Cremation . Signature of Funeral Service Licenses Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_sician/ MYOCARDIAL INFARCTION HOURS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner GYEARS CORDHARY ARTERY DISEAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death 9 | Inknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown The law requires 1 Tes DIABETES MECCITUS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsv performe 1 🗌 Yes 2 🔼 No certificate Yes 🗝 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🔼 No 1 Melnpatient 2 ER/Outpatient 3 DOA ဂ္ this funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 1 🔀 Natural 5 Pending injury work? 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe De conforme per ainquer, MD 1182000 SEPTEMBER 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUILLEAMO JOSE GIANGRECO 301 HOSPITAL DRIVE, GLEN BURNIE, MD 20161 31. Date filed (Month, Day, Year, 🕏. Registrar's Signature State SEP 7 Registrar

		•	For State Registrar	State of Mar	yland / Dep <i>Ce</i> .	artment of I <i>rtificate of L</i>	Health and Death		giene2010 Reg. No.	27840
	Physicia		1. Decedent's Name (First, Middle, Late Regina G. Pit					2. Date of Dea	ath	3. Time of Death <b>2:40 A</b> M
ر سار ار	Medic Examin		4a. Facility Name (if not institution, give 12800 Bridlepath	street and number) Road		4b. City, Town, o	r Location of Deat rstown		4c. County of De Baltim	ath
-	Funeral Director		5. Social Security Number 6. S 220–14–1891	_ ~	n yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h v, Year) 1, 1918 Bal	sirthplace (State or Foreign country) Linore, Maryland
	faryland Ba-f show tified at	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimo:	re	Oc. City, Town or Lo Reisters					10d. Inside City Limits 1 ☐ Yes 2 🛣No
	with the N 23a or 21 ust be not	Funeral Director	10e. Street and Number 12800 Bridlepath	Road		10f, Zip Code 21136			10g. Citizen of What C United S	Country? tates
9036	e 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Fun	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify: Wh	,
21215-0036	vithin 72 hou iene. r than "natu the Medical	Completed by	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)		(Give	dent's Usual Occup kind of work done o O NOT use retired) TIPE Maker	during most of wor	rking	16b. Kind of Busines  Own Home	is Industry
Maryland 2	d be filed v Aental Hyg Irked othe	To Be	17. Father's Name (First, Middle, Last)  Vincent Paul King					me (First, Middle, Dehauelle	Maiden Surname)	
2	id 2 should saith and N n 27 is ma er trauma		19a. Informant's Name/Relationship (1 Mr. Vincent C. P						r, City or Town, State, A ltimore, M	
Baltimore,	Page 1 ar ment of He tant: If iter ury or oth		20a. Method of Disposition 1   → Burial 2   → Cremation 3   → 4   → Donation 5   → Other (Speci	Removal from State	20b. Place of Disponentery, cre.	osition (Name of matory or other place Mer Cemeter	y Sept	Date • 08,2010	20c. Location - City of Baltimore	or Town, State , Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Ligen:	Jeffrey L. G (Lic. # M006	air, Sr. <sup>2</sup>	2. Name and Addre Peaceful A 2325 York F	ss of Facility Itematives Road Timor	Funeral (	& Cremation C land 21093	enter, P.A.
-	Physician/		23a. Fart 1. En or the dise e, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.					ė.	Approximate Interval Between Onset and Death
	Medical Examiner	بيد	resulting in death)  Sequentially list conditions,	Due to (or as a co	onsequence off:	famire	Hear	Dis	ec	10 xrs
	sate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or implry that initiated events resulting in death) Last	c. Due to (or as a co	onsequence oi):					
09/89	icate be physicial sthe bur	ledical		d						
Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death.  Luneral Director, After this certificate has been signed by the attending physician and atted filled in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transities.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ※ No 9 ☐ Unknown	23c. If yes, outcome of a line Live Birth 2 line 4 Pregnant at tire g Unknown	Fetal death 3	Ctopic pregnand Other (specify)	су		23d. Date of a	delivery Day Year
ls, P.O.	uires that the n signed by t uld be detach		Part II. Other significant conditions of	ontributing to death but I	not resulting in the	underlying cause gi	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?  Probably 4  Unknown
of Vital Records,	The law require cate has been si page 2 should	Completed by						24a. Was autor perfo 1 □ Yes	osy prior to rrmed? death'	autopsy findings available o completion of cause of ? /es 2 \( \sum \text{No} \)
/ital	nysician: The nis certificate director, pag	a	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	0 □ EB/0:44ia	Oth	lace of Death (Che		I 2   01/2   02	
on of V	ttending Phy death. stor. After this the funeral d	icate: To	27. Manner of De th  Natural 5 Pending Accident Investigatio	28a. Date of injury (Month, Day, Y	2 ER/Outpatie  28b. Time o injury	f 28c. Injur work	y at		dence 6 Other (Speciow injury occurred	ecity)
Division	tal or Attend rs after death al Director:/ ed in by the f	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S		reet, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	(Check 2 Medical Exam	sician: To the best of my iner: On the basis of exan se Practioner: To the bes	nination and/or inves	stigation, in my opini	on, death occurred	at the time, date a	and place, and due to th	e cause(s) and manner stated.
	To the within 2		29b. Signature and title of certifier	relux MD		29c. Licens			29d. Date signed (Mor	nth, Day, Year)
15			30. Name and address of person who	completed cause of deat		Print)	10120 Rg S	() TE	305	
	Stat Registra		31. Date filed (Month, Day, Year) SEP 0 7 2010	32. Registrar's	Signature San		1-1/	11 1 8 17	J 100 3	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death SEPTEM BER Day Physician/ 3:00 AM PHILIPS JESSE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Hours May 17, 1921 Pennsylvania 89 Director 198-10-1291 Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10d. Inside City Limits at 10a, State within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 KNo Dunda1k MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 7706 Trappe Road 21222 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No WWII 1 Never Married 2 TMarried Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐KNo Specify: Specify: White 3 Divorced 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur ury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Elementary/Seconday (0-12) College (1-4 or 5+) Maryland 10 Years Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sadie Oberlander Paul Philips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21224 Cameron Ailiff (Nephew) 330 Elrino St. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. 1 🖾 Burial 2 □ Cremation 3 □ Removal from State -9/4/2010 4 Donation 5 Other (Specify) Baltimore, Maryland Gardens of Faith Cem. 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland 21. Signature of FM Inc. 21222 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician RESPIRATORY FAILHRE WK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ULMONARY ED EM A IWK Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and HEART FAILURF 10 YRS CONGESTIVE for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No sate has been signed by the apage 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🗌 No **Division of Vital** 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) RES-000 SEPTEMBER 2,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar STEVEN HSU,

31. Date filed (Month, Day, Year)

SEP 0 7 2010

SEP 0 7 2010

SEP 0 7 2010

MD

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AVENUE

EASTERN

21224

BALTIMORE,

10-0	6449	
Dian	a Lynn Patten	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible: 0 | 0 27842 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certi	ficate of D	eath		Re	eg. No.	
Physici		Decedent's Name (First, Middle,Last)					Date of Deal     Month	th Day Year	3. Time of Death
ledical Exam	iner	Diana Lynn Patten		- [4:	50 <b>=</b>		August 26	, 2010	0750 hrs
		Facility Name (if not institution, give street and number)     Lexington Road			City, Town, or Loca lanover	ation of Dear	1	4c. County of De Anne Arund	
Funeral			(In yrs. last			Under 24Hrs	s. 8. Date of Bir	th (MM/DD/YYYY) 9. I	
Director		212-90-2381 1 <sub>M 2</sub>	47	-		Hours Min		For	eian
		Usual Residence of Decedent	7,	119.			Augusi	20,1903	Country)Maryland
any			Oc. City, To	own or Location		_			10d. Inside City Limits
	7	Maryland Anne Arundel		Harmans					1 Yes 2 No
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland neur of Health and Mental Hygiene. If itiem 27 is marked other than "natural?", or items 23a or 28a-f show in other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	-	10	of, Zip Code		10	0g. Citizen of What Co	ountry?
the N sa or S		6 Lexington Road			21077			United Sta	atos
n with	Funeral	11. Marital Status 12. Was Decedent E	ver in U.S.		ecedent of Hispanio			- 14. Race - Am	erican Indian, Black,
death or ite	Ē	1Yes 2 v	No	if Yes,	specify Cuban, Mex	xican, Pueπo	Rican, etc.)	White, etc.	
s after raf", iner	ğ	3 Widowed 4 X Divorced If Yes, Give Year or Dates:			s 2 No spe				√hite
hours natu	eted	15. Decedent's Education (Specify only highest grade comp  Elementary/Secondary (0-12)  College (1-4 or 5+		6a. Decedent's l during most	Usual Occupation (0 of working life, DO I	Give kind of v NOT use reti	work done ired)	16b. Kind of Busines	s/Industry
36 vin 72 s. shan '	ple	Elementary/Secondary (0-12) College (1-4 or 5+	')	Recep	tionist			Dental (	)ffico
5-0036 led within 7 Hygiene. I other than	Comple	1 Z				other's Name	(First, Middle, N	Maiden Surname)	711166
11215-0036 In the filed within 72 hours after the Hygiens Hygiens and sarked other than "natural?, event, the Medical Examiner	Be C	Stewart Gravely				elma S		,	
2121 ould be fi 1 Mental   5 marked ic event,	To	19a. Informant's Name/Relationship (Type, Print )		19b. Mailing Ad	dress (Street and	Number or F	Rural Route Num	ber, City or Town, Sta	ite, Zip Code)
and 2 shou fealth and N tem 27 is n traumatic		Velma Smith/ Mother	- 11	1057 6	th Street	,Glen	Burnie,	Marvland 2	21060
re, f Heal f Heal f iten		20a. Method of Disposition  1     Removal from State		ice of Disposition	(Name of cemeter	у,	Date	20c. Location - City	or Town, State
MOre Pages I rent of H ant: If i		4 Donation 5 Other Specify:		owridge	Memoria1	. 8/3	31/2010	Elkridge,M	Marvland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 beparative to fleath and Mental Hygiene. Important: If tiem 27 is marked other than injury or other traumatic event, the <u>Medical</u>		21. Signature of Funeral Service Licensee		22. Nam	e and Address of Fa	acility Gar	ry L. Ka	ufman Fune	eral Home.Inc
E. E. A. B. 60	8 8	Caul Nague		7250	) Washing	ton B1	vd.,E1k	ridge,Mary	land,21075
Physician /Medical		23a. Part I. Enter the disease, or complications of at caused the failure. List only one cause on each line.	ré death. D	o not enter the n	node of dying, such	as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)							Death
		- Strangulation	uence of):						
	Je.	if any, leading to immediate  Due to (or as a consequence)	uence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence)	uanaa afi:						
ecuted and transit		events resulting in death) Last Due to (or as a consequence of the constant of	derice or).						
a a e	/Medical	UNPENDED AMENDED							
68760, certificate be ex ading physician se as the burial	Med	IF FEMALE: 23c. If yes, outcome	of pregnar	псу				23d. Date of delive	ery
687 ertific ding p		23b. Was decedent pregnant in the past 12 months?		2 Fetal d	eath 3 Ec	ctopic pregna	incy	Month	Day Year
Sor ut	siciar	1 Yes 2 No 9 V Unknown 9 Unknown	ne of death	5 Other	(Specify)				
	Phy	Part II. Other significant conditions contributing to death b	out not resu	Ilting in the unde	rlying cause given i	in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
(ecords, P.O. B The law requires that the de ate has been signed by the age 2 should be detached	ğ						1 Yes	2 <b>✓</b> No 3 □ Pr	obably 4 Unknown
of Vital Records, ng Physician: The law requir the this certificate has been si meral director, page 2 should t	Completed						24a. Was a		autopsy findings available
COT law i	ם						autops perform	med? death?	completion of cause of
<b>02</b> L 13 G		25. Was case referred to medical			26.Place of De	onth (Chook o	1 Yes 2	! No 1 ✓ `	Yes 2 No
of Vital ing Physician: After this certif funeral director,	o Be	examiner? Hospital:   Inneticat	2 EF	₹/Outpatient 3	DOA Other			Residence 6 🗸 Oth	er: Scene
n of V ding Phy After th funeral of	<b>⊢</b>	27. Manner of Death 28a. Date of Injury	28	Bb. Time of Injury		Vork?	28d. Describe h	ow injury occurred	
	tio	1 Natural 5 Pending FOUND: Pounding Aug 26, 2010		OUND: 740 hrs	1 Yes 2	2 ✓ No	Subject strar	ngled	
Division tal or Attendi rs after death.	fica				ctory, office building	g, etc.			Rural Route Number, City
Divi	Certification:	4 Homicide determined (Specify) Singl	e Family	/ Home		6	or Town, St 8 Lexington Ro	ate) bad, Hanover, MD	
Hosp 24 ho Fun etely f		29a. Certifier 1 Certifying Physician: To the best of my k							
Division  To the Hospital or Attendi within 24 hours after death. To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated.	nation and/	or investigation,	in my opinion, death	h occurred at	t the time, date a	and place, and due to t	the cause(s)
	Ž	29b. Signature and title of certifier			29c. License num	nber		29d. Date signed (M	onth, Day, Year)
		40M			O.C.M.E.			August 27, 2010	0
101		30. Name and address of Jerson who completed cause of dea	•	,					
6		Jack Titus MD. Deputy Chief Medical Exa		111 Penn S	Street, Baltimor	re, MD 21:	201		
St Regist	~~~	31. Date filed (Month, Day, Year) 32. Registrar's SEP 0.7 2010	Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 27 20°10 8:40 Dorothy Marie Paetz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days May 18, 1 M 2 X F New York T922 086-14-2946 88 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Baltimore Baldwin MD 1 ☐ Yes 2 To No 10g. Citizen of What Country? 10f. Zip Code 21013 10e. Street and Numbe Completed by Funeral 12 Windy Manor Court Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify. 3 → Widowed 4 □ Divorced Year or Dates. 16b. Kind of Business Industrun 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Joseph A. Davey Gertrude A. Neubauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12 Windy Manor Court; Baldwin, Maryland 21013 Gail Kiddy - daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Son RONAL 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease condition resulting in eath) Pnysician/ uman Medical e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has a completed filled in by the funeral director, page 2 s autopsy 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᇛ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Registrar DHMH 17 Rev 7/2009

State

29a. Certifier

only one) 29b. Signatur

31. Date filed (Month, Day, Year)

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

AUGUST

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20¥0 Peak Hazel Virginia 10:50p M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster 5 Social Security Number 7. Age (In yrs. last birthday) 93 yrs If Under 1 Year | If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 6 Sex Funeral Days MAR<sup>th,</sup> 19 Year 1917 1 ☐ M 2 ☐XF West Virginia 215-30-0825 Director Usual Residence of Decedent In than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 🗓 No Carrol1 Sykesville Maryland 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? USA 21784 110 Terrapin Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 XNo þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I **other than "** College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Domestic 6 2 should be filed w h and Mental Hygi 7 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Julia Lula Testerman Elsie Isham Vernon other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health as
Important; If item 27 is
any injury or other trau David A. Peak, Sr./son 408 Ross Drive Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 😾 Burial 2 🗆 Cremation 3 🖵 Removal from State Dulaney Valley Memorial Gardens 9/4/2010 Timonium, MD Donation 5 Other (Specify) Signature of Funeral Sen P.O. Box 195 Sykesville, MD 21784 (410-795-1400 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition elelse utsucces Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Let Completed by Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months: Month Day Year Pregnant at time of death 9 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Pres 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: ဂ္ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of paramiation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner of the basis of paramiation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur 30. Name and of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mo Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 25 20Tb Mary Frances Picciano AKA Mary Frances Picciano-Milner 9:00  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 12403 Glen Mill Road Potomac Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗶 F Months Hours Min December 19 175-38-7797 63 **Director** Yrs. 1946 Pennsylvania Usual Residence of Decedent or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits Maryland Montgomery Potomac 1 ☐ Yes 2 🛣 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 12403 Glen Mill Road 20854 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic
once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institutes College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Senior Scientist of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ Dante Picciano Rose Pivone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Milner / Husband 12403 Glen Mill Road, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State September 2, 2010 Montgomery Crematorium, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NON-SMAL LIZNE disease or condition resulting in death) YEARS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to in recta cause. Enter Underlying Due to for as a confectional of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury signed by the attending physician and doe detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year should be detached g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed? Yes 2 No this certificate 2 No 1 Tes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕰 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: s after death. 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Hospital Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIH,

32. Registrar's Signature

ARUN

Arun Rajan, M.D.

31. Date filed (Month, Day, Year)

KASAN AM

01061307A

10 Center Drive, Bldg 10, Bethesda, Maryland 20892

DHMH 17 Rev 1/2001

Registrar

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Geraldine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANICE V. PERKY September 2010  $10:330^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours 8/29/1936 Mary land 219-34-6977 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Lutherville Maryland 1 Yes 2XXNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 821 Morris Ave 21093 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 21/21 Elementary/Seconday (0-12) Office Administrator Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Vinton Harriet Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Perry / Son 605 Talbott Ave. Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Towson, Maryland 4 Donation 5 Other (Specify) 9/7/2010 Hilltop Serv. Corp. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final HEMATOMA Ph sician/ SUBBURAL Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consquence of Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day n signed by the at Id be detached fo 1 Yes 216 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Thyroid Cancer, atrial tibrillatur Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? deep venins Thrombosis 24a. Was *a*n has autopsy performe After this certificate 2 X No \_\_ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: မ 2 X No 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director; After thi filled in by the funeral Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending FALL 1 ☐ Yes 2 😾 No 9-3-2010 Accident Suicide Investigation 6 Could not be 9 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide LUTTEMINE TIMORUM MD HOME within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Patrice atmodelins D27209 914/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10755 FALLS RO #200 LUTTERWILLE, MD 21093 SAVADEL, MD 31. Date filed (Month, Say Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEP TEMBS 5 Year **Physician** IAN 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROSEDALE BALTIMORE FRANKLIN QUARE HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖫 F 218-36-748 Director 69 10-25-1940 | Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at Baltimore Perry Hall Md 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21234 8342 Poplar Mill Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "n any Injury or other transment." Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Accountant United Way Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Livia Marcantonio William Joseph Leonard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter Pamela A. Messina 2901 Md. 21234 Glendale Avenue Baltimore, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Parkwood Cemetery 9-9-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Saneral Serpice Licenses 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. Conkling Street Balto. Md. 23a. Part 1. Enter the dis shock, or heart fringe. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SPIRATORY /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed iclan and burlal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiclan Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who

31. Date filed (Month

completed cause of death (Item 23a) (Type, Print)

32. Registrar's

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2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27849 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RACFORD Physician/ 053U M 190 2Vear U ARLI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-48-3337 1 M 2 7 F 76 Months Days Hours Min. (Month, Day, Year, Director DC /8/1934 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Moutral Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George' Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16010 Excalibar Rd #D211 20716 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Black ð 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper 12th Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Claude Braxton Beatrice Weldon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16010 Excalibar Rd., #D211, Bowie, MD 20716 James B. Raeford-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Ft. Lincoln Ceme. 9/10/2010 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DL McLaughlin Funeral any in uneral Service Licenses 2019 Martin Luther Kg Ave SE Wash DC20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition \* Medical resulting in death) Due to (or as a consequence of): **Examiner** HTN Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Day Pregnant at time of death 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 N Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier when 012010 Name and address of person who completed cause of death (Item 23a) (Type, Print) IENTA IM EFENSE

DHMH 17 Rev 7/2009

Registrar

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completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number death (Item 23a) (Type, Print) arlane Columbia MD 2/044 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

10-06349	Please Type or Print in Black Indelik		
Walter E. Rogers		ent of Health and Mental Hygiene	2010 2785
	Registrar	te of Death	Reg. No.
Physician/ Medical Examine	TYMITE E. HOUELS		st 22, 2010 Year 1930 hrs
	4a. Facility Name (if not institution, give street and numb∳r) 334 E. 25th Street #6	4b. City, Town, or Location of Death  Baltimore	4c. County of Death
Funeral	Social Security Number     Social Security Number	l	of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	216-90-8330 1XM 20F 47	Mantha Dava Haves Min	23,1963 Foreign Country) Md.
o kue	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o	r Location	10d. Inside City Limits
3	MA N/A Bal	timore	1 Yes 2 No
the Maryland a or 28a-f show tiffed at once, Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
with the Maryland as 23a or 28a-f she contilied at once stal Director	334 E, 25th St.	21218	USA
r death with or items 2 must be n	11. Marital Status 1 Never Married 2 Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.</li> </ol>	
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136 hin 72 hours afte e. than "natural", edical Examiner	15. Decedent's Education (Specify only highest grade completed) 16a. D	ecedent's Usual Occupation (Give kind of work done	16b. Kind of Business/Industry
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D 21214 should be fil and Mental I 7 is marked natic event,	9a Inform n' Name/Relationship (Type, Print) SIS ET 19b.	Mailing Address (Street and Number or Ru ) out	e Number, City or Len, State, Zip Code)
MD d2 sho	Mrs. Delores Fletcher 20	143 Rosalind Ave	Balto Md 21215
- 5 6 5 5		Disposition (Name of cemetery, Date ry or other place)	20c. Location - City or Town, State
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Baltimore, permit. Pages I a Department of He Important: If ite	21. Spriature of Funeral Service License	22. Name and Address of Figure 70500 Luss Fu	neral Home PA.
	23a. Part I. Enter the disease, or complications that caused the death. Do not	12222 W. North Ave	ry arrest, shock, or heart Approximate Interval
Physician /Medical	failure. List only one cause on each line.	enter the mode of dying, such as caldiac of respirato	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Cardiomegaly  Due to (or as a consequence of):		334
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Box 68760, e death certificate be the attending physic ed for use as the bur hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
ox 6 ath ce attend attend or use	Pregnant at time of death 5	Other (Specify)	
). Box 68760, the death certificate be enough the attending physicia ched for use as the burial Physician/Medi	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I 23e.	Did tobacco use contribute to the cause of death?
, P.O. Box 68760, res that the death certificate be signed by the attending physici be detached for use as the burid by Physician/Med	Hypertension, Diabetes,Obesity		Yes 2 No 3 Probably 4 Unknown
rds, requir been s bould b			Was an 24b. Were autopsy findings available
Records,  The law requires ficate has been sig			autopsy prior to completion of cause of death?
nrifical Co., pa.	25. Was case referred to medical	26.Place of Death (Check only one)	Yes 2 No 1 Yes 2 No
f Vital Physician or this cert ral directo	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Out	patient 3 DOA Other Nursing Home	5 Residence 6 ✔ Other: Scene
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact extification: To Be Completed by P	1 Natural (Month, Day, Year)		cribe how injury occurred
Sion trend death. cror: y the f	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	
Division o spiral or Attending hours after death. neral Director: Aft filled in by the fune Certification:	determined (Specify)		tion (Street and Number or Rural Route Number, City wn, State)
Lospit 4 hour funers ly fill	29a. Certifier	h occurred at the time, date and place, and due to the	a cause(s) and manner as stated
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transis Medical Certification: To Be Completed by Physician/Medical Ex	one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.		
T 3 T 3	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	4 M. The for	O.C.M.E.	August 23, 2010
_	30. Name and address of person who completed cause of death (Item 23a)	444 Dana Charle D. III	
State		111 Penn Street, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day Year) SEP 0 2010 Server 32. Registrary Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09/06/2010 John Ray Ruffin 6:40a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4105 Park Heights Ave. Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD Min. 12-19-1955 1**X**XM 2 □ F Months Hours 54 Director 220-68-3107 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4105 Park Heights Ave. 21215 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0. Black, White, etc. 1 Never Married 2 Married Completed by 1XXYes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ould be filed within 72 hours afted Mental Hygiene.

marked other than "natural", 1975-Specify: Black 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Environmental Service Elementary/Seconday (0-12) College (1-4 or 5+) Custodial Service 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester Ruffin Helen Graham should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Deborah A. Ruffin / Wife 5105 Pembridge Ave., Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory | 09/07/2010 Odenton, MD 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Road, Halethorpe, MD 21227 21. Signature of Funeral Service Licensee M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Securations list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Let Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a d be detached t 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2X No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2**X** X No 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🔀 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home SXX Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work? 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a

To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 09/07/2010 car 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Keith Pratz, M.D

31. Date filed (Month, Day, Year)

N. Broadway, Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 4,2010 Elizabeth Grace Rowe 6:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Baltimore Stella Maris If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Feb. 25, T921 Pennsylvania 203-01-7162 89 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Director MD Baltimore Baltimore 1 ☐ Yes 2 🖾 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 8715 Raven View Avenue 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3√ Widowed 4 □ Divorced Completed and Mental Hygiene.

is marked other than "naturraumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) At Home Homemaker 12 Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary McHugh Joseph McDonough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Meller-daughter 4413 Old Philadelphia Road-Aberdeen, Maryland 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept.8,2010 Dulaney Valley
Memorial Gardens 1 XBurial 2 Cremation 3 Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses R. Name and Address of Facility
Pans Funeral Chapel and Cremation Services
0000 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, had not be immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a conse uence of attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No Year Month Day signed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy perforn 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **X**No Other: ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After inpleted filled in by the funer injury work? 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Cartifying Number Practice of Texthere at July 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

202

SEPTEMBER

RITH

Euz

2300 DULANEY

30. Name and apdress of person who completed cause of death (Item 23a) (Type, Print)

JACILLE DONES GANP

2010

VALLEY RO THONIUM MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 8:00 P M SEPT. MARGARET R. RYTTER 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 8620 KELSO DR., APT. 209 Essex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 F 215-16-6538 89 JUNE 25, 1921 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the IV-dical Expriner must be notified. 1 ☐ Yes 2 ☐ No Director MD Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8620 Kelso Dr. Apt. 209 21221 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify If Yes, Give Year or Dates: Specify: WHITE <u>ک</u> 3 → Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any in]ury or other traumatic. Elementary/Secondary (0-12) HOMEMAKER OWN HOME 12TH 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES F. RAU, JR. MARGARET K. WARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Simms/daughter 8240 Long Point Rd., Balto., MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ATLANTIC CREMATORY GLEN BURNIE, MARYLAND 9/3/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugeral Service Licensee

22. Name and Address of Facility

Lemmon Funeral Home of Dular

10 W. Padonia Rd., Timonium

23a. Part 1. Enter the disease or complications that caused the death shock, or heart failure. List only one cause on each line. Lemmon Funeral Home of Dulaney Valley, Inc. Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE

Due to (or as a consequence of): **Physician** /Medical CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi Exami HYPERTENSION be execute and Due to (or as a consequence of) Box 68760 physician ANEMIA Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 C Ectopic pregnancy ρ Month Day Year 5 Other (specify) P.0. ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 **N**o this certificate 1 ☐Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner Death 1 Natural After Division Hospital or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State 'Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

use of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

ROBINSON, JR.

63

10c. City, Town or Location

SR.

2. Date of Death

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

**Physician** /Medical Examiner

4a. Facility Name (If not institution, give street and number)

406 S. CHAPEL STREET

BALTIMORE

SEPTEMBER 3, 2010 3:30a M

**Funeral** 

Director

ir than "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at Director Funeral ģ Completed other Be and Mental I Pages 1 and 2 should be

Maryland 21215-0036

Baltimore,

**EDWARD** 

4b. City, Town, or Location of Death

4c. County of Death N/A

5. Social Security Number 215-46-8961

7. Age (In yrs. last birthday) 12XM 2□F

Yrs

If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min.

8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) 99/26/1946 MARYLAND 9. Birthplace (State or Foreign

Usual Residence of Decedent 10a State 10b. County

> MD N/A

BALTIMORE

1X Yes 2 □ No

10e. Street and Number

406 S. CHAPEL STREET

21231

10f. Zip Code

10g. Citizen of What Country? U.S.A.

11. Marital Status

1 Never Married 2 Married 3∑ Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 11

College (1-4or 5+)

CARPENTER

CONSTRUCTION

17. Father's Name (First, Middle, Last) EDWARD MICHAEL ROBINSON,

VIRGINIA LEAH DUDEK

18. Mother's Name (First, Middle, Maiden Surname)

19a Informant's Name/Relationship (Type, Print)
Robin Ali/daughter

193 Mailing Address (Street and Aumber or Rural Route Number, City of Jave State, Zip Code)
406 S. CHAPEL STREET, BALTIMORE, MD. 24 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

STACY JONES 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

HOLLY HILL MEMORIAL 9/6/10

MIDDLE RIVER, MD

21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22 Name and Address of Facility LILLY & ZEILER d Address of Funeral HOME EASTERN AVENUE, BALTIMORE, MD 1901 21231

**Physician** /Medical Examiner

> burial-transit and

the use as I

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has

within 24 hours after death. To the Funeral Director: After this certific cumpletely filled in by the funeral director,

5

To the Hospital

The law requires that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

Examiner

Physician/Medical

ģ

Completed

Be

Medical Certification; To

t of Health a

5 Department of Important: If eny injury or once.

Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

y epatosellular Due to (or as a consequence of Due to (or as a consequence of)

Due to (or as a consequence of):

2 MUNTY

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy

23d. Date of delivery Month Day

9 Unknown

4 Pregnant at time of death 9 Unknown

5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

1 Yes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 10 3 Probably 4 Unknown 24a. Was an autopsy performed?

2 € No

1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

2 No

25. Was case referred to medical 1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day Year)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

26. Place of Death (Check only one)

28d. Describe how injury occurred

1 Natural 2 Accident 3 🗌 Suicide 4 THomicide

29a, Certifier

27. Manner of Death

5 Pending investigation 6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dav. Year)

019714

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UFTEIL

MICHARL 31. Date filed (Month, Day, Year)

YU ENTIONY AJE BALTING 11 2,224 14BUML 32. gistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August MaryAnn E. Ryder 2010 1:15am Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Carrol1 4b. City, Town, or Location of Death **Examiner** 6504 Chantilly Drive Sykesville 8. Date of Birth Month, Day, Year Apr 16, 1949 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 NT T If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🏋 Months Hours NJ 153-38-6731 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 No Carrol1 Svkesville 23a or 3 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumation." 21784 USA 6504 Chantilly Drive 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2 No Specify. If Yes, Give White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Care Salon Owner Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Romanoff Joseph Romanoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6504 Chantilly Drive Sykesville, MD 21784 Mr. James E. Ryder (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State 8/31/2010 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesvill, e MD21784 MO0769 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final Ph<sub>sician/</sub> Non Small Cell Months disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a sonsequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rector, page 2 1 🗌 Yes Yes 2 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ₹No ျ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No nours after death neral Director; A illilled in by the fi Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29c. License number 29d. Date signed (Month, Day, Year) 00056919 megan se of death (Item 23a) (Type, Print) 30. Name and address of person who completed ca 12 6569 N. Charles St. #205, Baltimore, Md M.D Robert Donegon State Registrar

P.O. Box 68760

		1	_ State	partment of Health and N ertificate of Death	Mental Hygiene Reg. No. 2010 27857
			Registrar  1. Decedent's Name (First, Middle, Last)		Date of Death     3. Time of Death
	Physicia		Annice R. Ripperger		August 29, 2010 7:41a <sup>M</sup>
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			870 Seneca Park Road	Middle Riv	
-	Funeral Director		5. Social Security Number $214-38-3093$ 6. Sex $1 \square$ M 2 $\square$ F $1 \square$ 7. Age (In yrs. last birthda Yrs	Months Davs Hours Min.	8. Date of Birth  (Month, Day Year)  June 30, 1939  9. Birthplace (State or Foreign Country)  NewYork
	d tt ow	. h	Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or	Location	10d. Inside City Limits
	a-f sk	Director	MD Baltimore Mid	dle river	1 ☐ Yes 2X No
	th the Ma 3a or 28 t be noti	ral Dire	10e. Street and Number 870 Seneca Park Road	10f. Zip Code 21220	10g. Citizen of What Country? USA
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	1 Never Married 2 Married 1 Yes 2 Mo	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1  Yes 2  No Specify:	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
8	ours atura cal E	etec	15 Decedent's Education 16a De	cedent's Usual Occupation	16b. Kind of Business Industry
5	72 h n "na Aedio	g.	(Specify only highest grade completed) (G.	ve kind of work done during most of work . DO NOT use retired)	
21215-0036	ithin jene.	S	Elementary/Seconday (0-12) College (1-4 or 5+) HC	memaker	own home
and 2	oe filed w ental Hyg ked othe c event,	To Be	17. Father's Name (First, Middle, Last) Wilfred Brydges	18. Mother's Nan Cat	ne (First, Middle, Maiden Surname) herine E. Kelly
Maryland	should I h and Me 7 is marl traumati		19a. Informant's Name/Relationship (Type, Print)  Ronald Ripperger /husband 87	ailing Address (Street and Number or Ru 70 Seneca Park R	oad Balto. MD 21220
	and 2 Healt em 2		20a Method of Disposition 20b, Place of Di	sposition (Name of	Date 20c. Location - City or Town, State
Baltimore,	Page 1 ment of tant: If it		1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garder 4 ☐ Donation 5 ☐ Other (Specify)		/10 Rossville MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	Connelly Fun	00 Mace Ave. Balto. MD eral Home of Essex 21221
	Physician/ Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the path. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	the bost Comi	Onset and Death
	be executed sician and burial-transit	al Examiner	Cause (Disease or linjury that initiated events resulting in death) Last   C. Due to (or as a consequence of):		
9	ate be hysic the bu	dical	d		
Box 6876	ss that the death certificate igned by the attending phys be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3	23d. Date of delivery  Month Day Year
, P.O.	es that the ligned by the be detach	l by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ຝ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	ompletec			24a. Was an autopsy findings available prior to completion of cause of death?  1  Yes 2  No 1 Yes 2  No
E B	in: Th ificate or, pa	Ü	25. Was case referred to medical	26. Place of Death (Che	
/ita	nysician: 7 nis certifica director, p	To Be	examiner? 1	patient 3 DOA Other: 4 Nursing	Home 5 Residence 6 Other (Specify)
n of \	ding Phy th. After this funeral c	ate: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year)  28b. Tir	ne of 28c. Injury at	28d. Describe how injury occurred
ivisio	or Atten after deaf Director; in by the	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
۵	To the Hospital or Attend within 24 hours after deatl fo the Funeral Director. completed filled in by the	Medical (		investigation in my opinion death occurred	at the time. Date and Diace, and que to the cause(s) and marrier states
	thin 2 the 1 the 1	ž	only one) 3	29c. License number	29d. Date signed (Month, Day, Year)
_	5.≥5.8			D40850	August 30,2010
5			30. Name and address of person who completed cause of death (Item 23a) (Ty		une Drive Baltonia MD 2123
b_	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's grature	el d	
/	Regist		SEP 0 7 2010 Change F. S.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 27858 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2010 5:58 P David Eugene Ryer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F 0*87227*4930 Baitimore, MD Director 213-26-7550 80 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Baltimore Ruxton Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 U.S.A. 901 Navy Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? or, Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates.1950-1955 1 Yes 2 No Specify: "natural", Specify: White 3 X Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ University Administrator Education Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked oth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catharine Hiemiller Eugene Henry Ryer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4307 Mainfield Avenue, Baltimore, MD 21214 <u>David Christopher Ryer/</u> son 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp.: 09/07/2010 Towson, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) neuman Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, anding physician and use as the burial-transit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Obstrution Ling Discase 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Certificate: To 2 300 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Brother (Specify) Hospic c 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00061199 mos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Touson, N CharlesST, Suite 4105, 6565 31. Date filed (Month Pay

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ - Month Em b Day Medical 4a. Facility Name (if not institution City, Town, or Location of Death 4c. County of Death **Examiner** N/AIf Under 1 Year If Under 24 Hrs. 8, Date of Birth . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛣 F Months Hours Min. Director 43 Yrs 1967 Maryland Usual Residence of Decedent show 10a. State 10b. County aţ 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits or 28a-f s notified 1X Yes 2 No MD N/A 1719 N. Carey Street 10e. Street and Number ò 10f, Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 1719 N. Carey Street 21217 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11th Grade unk it. Page 1 and 2 should be filed with trment of Health and Mental Hygien rtant: If item 27 is marked other I njury or other traumatic event, th unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ George Timpson Mary Bond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1719 N. Latonya Martin(daughter) Carey Street, Baltimore, MD 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If i any injury or or 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Western Star Cem. 09/09/10 Baltimore, MD <sup>22</sup>Jame and Address of Facility own Jr. Funeral Home PA 2140 N Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Dav Year been signed by the a 1 ☐ Yes 2 p g ☐ Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has ral director, page 2: performed?
1 Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After 5 Pending <sup>∆</sup> Natural s after death.

I Director; After director of the fur Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined 24 hours a Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29h Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Robert Smith Jr. 515 PM 4 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Rosedale Square Hospital FRANKLIN BalTimor € Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 15 M 2 □ F Months Hours 74 213 32 2159 **Director** Maryland Jan. 14, 1936 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits tems 23a or 28a-f shov Baltimore 1 ☐ Yes 2 X No Directo Maryland Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4405 Hallfield Manor Drive 21236 USA Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 □Yes 2∑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 'natural', or i 1 ☐ Yes 2 X No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Steel Mill 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Robert Smith Sr. Katherine Buckley ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4405 Hallfield Manor Drive Nottingham, Maryland 21236 Mary P.Smith (Wife) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayview Crematory Inc. 9/9/2010 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. lokn W. Durkniske 1407 Old Eastern Avenue Essex, Maryland 21221 23a. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive Intracranial Due to for as a consequence of): **Physician** Bieed resulting in death) /Medical Examiner FibrilLation ATRICAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Exami burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Was a autopsy performed? 24a. Was an has 2 🗆 No 1 □ Yes 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mi) 054736

State Registrar

Smil

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Ite

R

Kamluk

SEP O

31. Date filed (Month, Day, Year)

Auyeuns

32. Registrar's Signature

FRANKLIN Square DR Balto Md 21237

123a) (Type, Print)

9000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 31, 2010 ar 5:45P FLORENCE ERMA SAVIN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death None Keswick Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X Months 1990171995 New Jersev 94 219-42-6898 Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director YS 2 No Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 700 West 40th Street 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XXVo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: XX Widowed 4 Divorced Specify: "natural" White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Maximones. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Corbett David Nelson Susan Nichols 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815 Western Run Road Cockeysville Maryland 21030 Timothy A Savin Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

GreenMount Crematory 09/02/2010 20c. Location - City or Town, State Burial 2 
 Cremation 3 □ Removal from State |Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) gnature of Funera 22. Name and Address of Facilityohn O Mitchell IV Funeral Services of Dulaney Valley 200 E Padonia Road Timonium Maryland 21093 Part 1. Enter the disease, or com-shock, or heart failure. List only of ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) e to (or a a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy perform death?
1 Yes 2 No After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural within 24 hours after death.

To the Funeral Director; Aff completed filled in by the fur Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of

State Registrar

DHMH 17 Rev 7/2009

n 23a) (Type, Print)

670

30. Name and address of person who completed cause of death (ite

31. Date filed (Month, Day, Year)

Jean	Swinton	Smart

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	1- For State Registrar		Certii	ficate of	Death			R	leg. No.	10 51809
Physician/ Medical Examiner	1. Decedent's Name (First, Midd Jean S	. Smart						Date of Dea Month August 21	ath Day Year 1, 2010	1030 nrs
	4a. Facility Name (if not institution 5204 Pooks Hill Road	I			b. City, Town, o Bethesda	or Location	of Death		4c. County o	
Funeral Director	5. Social Security Number 484–52–3026	6. Sex 7. A	ge (In yrs. last	birthday) Yrs.	If Under 1 Ye  Months Da	_	der 24Hrs.	8. Date of Bi		Birthplace (State or Foreign IA  Country)
nd show any tee.	Usual Residence of Decedent  10a. State 10b. County  MD Mor	ntgomery	10c. City, To	own or Location Bethe						10d. Inside City Limits 1 Yes 2 No
the Maryland sa or 28a-f sh tiffied at once	10e, Street and Number 5204 Pool	ks Hill Road			10f. Zip Code	208	14	1	Og. Citizen of Wha	at Country? USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	s? 2 X No	If Ye	Decedent of H s, specify Cuba Yes 2 N	n, Mexicar o s <i>pecify</i>	n, Puerto R	ican, etc.)	White,	white
5-0036 ed within 72 hour: yggiene. other than "natu the Medical Exan	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12	College (1-4 or		during mo	s Usual Occupa st of working life 1 Aid	e. DO NOT	use retire	d)		Legal
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	17. Father's Name (First, Middle Robert Jame)  19a. Informant's Name/Relations	es Swinton		40h Maigan	Add (8)	J	oyce	Maxin		
, MD 2 and 2 shoul salth and N sm 27 is m raumatic		n / Nephew	1	1226	52 112t	n Ave	nue,			
Baltimore, permit. Pages 1 ar Department of Hee Important: If iten mjury or other tr	1 Burial 2 Cremation	n 3 K Removal from S	tate Gree	natory or other een Woo	od Cem		8/3	0/10	Nashu	a, IA
Physician Physician	21. Signature of the disease, or 23a. Part I. Enter the disease, or	complications that cause	d the death Do	15	aries 1	t For	evens t Ave	Funer nue, B	ral Home, Saltimore	Inc. MD 21230
/Medical Examiner	failure, List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	Cardiovas							Between Onset and Death
Jer	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cons								
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):							
7760, ficate be executed g physician and the burial - transit	UNPENDED	d AMENDED								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiledical Certification: To Be Completed by Physician/Medical Ei	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	I Live biltin	me of pregnan	2 Feta	I death 3 er (Specify)	Ectopio	c pregnanc	у	23d. Date of d Month	elivery Day Year
s, P.O. laires that the a signed by t d be detache ed by P.P.	Part II. Other significant condit	ions contributing to deal	th but not resul	lting in the un	derlying cause	given in Pa	art I.	23e. Did to		ute to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stater death. The this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	25. Was case referred to medica				26 Place	of Death	(Check onl	1 Yes	sy pri m <u>ed</u> ? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Vital ysician ysician director	examiner? 1  Yes 2 No	Hospital:	ent 2 ER	/Outpatient		Other <sub>4</sub>	-		Residence 6	Other: Scene
ion of Vi ttending Physi leath. tor: After this the funeral din ation: To	27. Manner of Death 1  Natural 5 Pend	28a. Date of Inj (Month, Day,) ding stigation	ury 28 Year)	b. Time of Inju	′ I _′	ry at Work Yes 2	. 1	d. Describe f	now injury occurred	
Division o spital or Attending tours affect death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Coul 4 Homicide	d not be mined (Specify)	njury - At home	, farm, street,	factory, office t	ouilding, et	c. 28	or Town, S		or Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	one) 2 Medical Exa	nysiclan: To the best of m miner:On the basis of exa and manner stated.			n, in my opinior	n, death oc				
	29b. Signature and title of certifie	re Soule	1		29c. Licens				29d. Date signed August 22, 2	(Month, Day, Year)
?	30. Name and address of person Margarita Korell MD.	Assistant Medical	Examiner	,	nn Street, B	altimore	, MD 21	201		
State Registrar	31. Date filed (Month, Day, Year)	2010 32. Registra	ar's Signature	ha	of S					
DHMH 17 Rev 1/2001 OCMF 2006	SET V	SUIU LEAD	o p.	RIGINAL	100					OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depar	tment of Health and M		2010	27863
			Registrar Certif.  1. Decedent's Name (First, Middle, Last)	Ticate of Death	Reg. 2. Date of Death	1407	3. Time of Death
	Physicia Medic		Michael Shacka			Day 31 Year	0 0935 M
	Examin	er		b. City, Town, or Location of Death		4c. County of Death	
	Funeral		5 Social Security Number 6 Sex 7 Age (In virs last highday)	Baltimore, UD If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Baltimor	pplace (State or Foreign
	Director			Months Days Hours Min.	(Month, Day, Yea	29 Mar	vland
	nd how at	ř	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat	tion			10d. Inside City Limits
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	<b>Funeral Director</b>	MD Anne Arundel Millersvil				1 ☐ Yes 2 🏋 No
	the Nor 28	Ξ	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	untry?
	h with	nera	925 Oakdale Circle	21108		U.S.A.	
	r deat or iten liner r		Armed Forces? If Ye	s Decedent of Hispanic Origin? (Spec es, specify Cuban, Mexican, Puerto R	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
28	s afte ral", c Exam	q pa	1 ☐ Never Married 2 ☑ Married 1 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Year or Dates.	Yes 2 No Specify:		Specify: Wh	ite
5 - -	2 hour "natu	Completed by		nt's Usual Occupation d of work done during most of workin	16b	. Kind of Business li	ndustry
Maryland 21215-0036	thin 7, sne. than the Me	E O	Elementary/Seconday (0-12) College (1-4 or 5+)	NOT use retired)		T T	
Q N	led wi Hygie other ent, t	Be (	17. Father's Name (First, Middle, Last)	enter  18. Mother's Name	(First, Middle, Maide	Home Impr	ovement
/lan	d be fi Aental arked ttic ev	잍	Michael Sebastiano Shacka	Rita Bily			
lan,	should be file h and Mental H 7 is marked o traumatic eve			Address (Street and Number or Rural			
	and 2: Health em 27 ther tr			akdale Circle Mi			
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cremati	fory or other place) 9/8/		Location - City or 1	
	nit. Partme bartme bortan injuny			Crownsville 201		cownsvill	
ñ	permit. Departr Importa any injt			vices, PA 1 2nd A			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	he mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
H	Pnysician/		Immediate Cause (Final disease or condition			- 1	Onset and Death
	Medical Examiner		Due to (or as a consequence of):	Lung			sun the
	-	Jer	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):	2019			7-4011100
	d d ansit	ami	cause. Enter Underlying Cause (Disease or linjury that initiated events				
	executian an	dical Examine	resulting in death) Last  Due to (or as a consequence of):				
20	ate be chysic the bu	dice	d				
200	ding page as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			22d Date of deli	
X Q	eath of atter	icia	in the past 12 months?  1	ctopic pregnancy Other (specify)		23d. Date of delive Month	Day Year
5	t the d by the	Phys	9 Unknown 9 Unknown				
7,	es tha signed be de	by	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		/	the cause of death?
ecords,	requir been s should	Completed					
ecc	e law e has l ge 2 s	dmo			24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
Ý	an: Th tificate tor, pa	a)	25. Was case referred to medical	26. Place of Death (Check of	1 Yes 2 🗹	No 1 Yes	2 🗆 No
VItal	nysicia nis cer direct	To B	examiner? 1	3 ☐ DOA Other: 4 ☐ Nursing Hom	ne 5 🗆 Residence	6 Other (Specif	· · · · · · · · · · · · · · · · · · ·
101	ing Pt		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of injury	work?	8d. Describe how inj	ury occurred	
<u></u>	ttend death stor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	05		/B + N - /
2	irec n by		4 Homicide determined 200. Place of Injury - At nome, farm, street, building, etc. (Specify)	, factory, office	8f. Location (Street a City or Town, Sta	te)	i Houte Number,
SINIS	di Da		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occi	ured at the time, date and place, and	due to the cause(s)	and manner as stat	ed.
DIVISION	ospital of hours a uneral D	dica	(Chaple 2 Madical Evaninary On the basis of evangination and/or investigation		ne tirne, date and pia	ce, and due to the ca	ause(s) and manner stated.
DIVIS	the Hospital of thin 24 hours a the Funeral D mpleted filled in	Medical	(Check 2 ☐ <b>Medical Examiner:</b> On the basis of examination and/or investigationly one) 3 ☐ <b>Certifying Nurse Practioner:</b> To the best of my knowledge, deat	th occurred at the time, date and place,			
DIVIS		Medica	(Check 2 ☐ Medical Examiner: On the basis of examination and/or investigationly one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, deal 29b. Signature and title of certifier	th occurred at the time, date and place, 29c. License number		ate signed (Month,	Day, Year)
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DIVIS	To the Hospital of within 24 hours at To the Funeral D completed filled if		(Check 2 Medical Examiner: On the basis of examination and/or investigationly one) 3 Certifying Nurse Practioner: To the best of my knowledge, deal 29b. Signature and title of certifier  29b. Signature and title of certifier  20 Name and address of person who completed cause of death (Item 23a) (Type Print)	th occurred at the time, date and place, 29c. License number  D 00 70226	29d. E	Pate signed (Month,	Day, Year)
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death County of Death more **Funeral** If Under 24 Hrs Sex 1 X M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign Months Min Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 □ No mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death 12. Was Desegent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ 21215-0036 1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa Specify: Completed 3 - Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) econday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Informant's Name/Relationship (Type, Print) Lsister 19b. Mailing Address (Street and Number or City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 2010 4 Donation 5 Other (Specify) o Funeral Service Licens Signatu . Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ver disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a hy, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) tor. After this certificate has been signed by the attending physician the funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital ျှ 1  $\square$  Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ther (Spe 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death Natural
Accident 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pendina work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Deficiency Physician to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier nd address of person who completed cause of death (Item

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

10-06637		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
John Edward Sc		State of Marylana / Department of Fledich and Mental Tryglene	27865
		Registrar Certificate Of Death Reg. No.	_
Physicia		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year	3. Time of Death
Medical Exami	ier	JOINT LAWING SCITT FEET, IT September 2, 2010	1527 hrs
1		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea  1339 Rigble Hall Court  Bel Camp  Harford	th
Funeral Director		Months Days Hours Min 0 00 1000 Fore	irthplace (State or ign
Director		20-13-1943 1XM 2 F 247 Yrs. 3-22-1706 C	ountry)/Vary lanc
>		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Location	
w any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
·land	ġ	THU Harrora Belaamp	1 Yes 2 No
Mary r 28a	Director	10e. Street and Number 10f. Zip tode 10g. Citizen of What Co	untry?
th the		1234 MIGDIE HOLL COULT   21111   V.S.	7.
th wir	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Ame White, etc.	erican Indian, Black,
or it	큔	1 Yes 2 No	hite
s afte	<u>a</u>	3 Widowed 4 Divorced It Yes, Give Year 1 Yes 2 No specify: Specify: Specify: U  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business	1/1/
hou:	E E	during most of working life. DO NOT use retired)	
36 iin 72 han	음	12 Electrician Consti	ruction
5-0036 led within? Hygiene. tother than	Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	BeC	Tohn E Schrieter Sr Patricia A Cu	SOOK
Z 2 9 8 3	일	19a. Informant's Name/Relationship (Type, Print ) (Futher) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stat	e, Zip Code)
imore, MD 2 Pages 1 and 2 shou ment of Health and N hant: If item 27 is n or other traumatic	-	JOHN & Schriebers A103 Allibra Rd Rel Are mi	21115
ore, MC s. 1 and 2 s of Health au If item 27		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of	r Town, State
NOTE, ges 1 a nt of He t: If ite		1 Burial 2 Cremation 3 Removal from State E Crematory or other place)	11:11
timer truer rrtan	- 1	4   Description   Other Country	#III MD
Baltimo permit. Page Department of Important:	- 1	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23. Name and Address of Facility  24. The Property of Funeral Chapter	21 - Belair
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of ding, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval
/Medical	- 1	failure. List only one cause on each line.	Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)  Narcotic and alcohol intoxication  Due to (or as a consequence of):	Deatri
	- 1	b	
	힐	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
	Examiner	(Disease or injury that initiated	
recuted and transit		events resulting in death) Last Due to (or as a consequence of):  d.	
executed ian and al - transi	isa	*XINPENDED Y AMENDED	
Box 68760, e death certificate be extitue the attending physician red for use as the burial-	ian/Med	#1 as noted, 23a, 27,28a-f,per ME G907 9/22/10 TT  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver	
rtifica ring p	2	23b Was decedent pregnant in the	Day Year
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v requ	Completed		utopsy findings available completion of cause of
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Tittice To	Ö	25. Was case referred to medical 26.Place of Death (Check only one)	2 140
/ita	ď	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing Home 5 Residence 6 Other	er: Scene
n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by finneral director, page 2 should be detach	-1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	-
on endin ath. or: A	ertification:	1 Natural 5 Pending (Month, Day, Year)  1 Natural 5 Pending Fd 9/2/10 Fd 1515 hrs 1 Yes 2 X No unk	
Division al or Attendir rs after death, al Director: A	밀	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R	
Divisior pspital or Attend hours after death ineral Director:	팅	Suicide 6 A Could not be determined (Specify) residence or Town, State) 1339 Rig	ble Hall Ct
Hosp 24 hou Fune tely fi	O	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as star	
To the within To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	
To with	₹	29b. Signature and title of certifier 29d. Date signed (Mo	inth, Day,Year)
		O.C.M.E. September 3, 20	)10
D Q	1	30. Name and address of person who completed cause of d ath (flem 23a)	
Ora	1	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Regist		SEP 0 7 2010 Server S. Sall	

10-06546 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 27866 Lorin England Spivey State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day August 30, 2010 Year Medical Examiner 1311 hrs Lorin E. Spivey 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1101 Bethlehem Avenue Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Countr Marry Land Director Months Days Hours Min. 214-86-5126 1XX M 38 May 24, 1972 2 F Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f show Maryland Maryland **Baltimore** Perry Hall is marked other than "natural", or items 23a or 28a-f shov atic event, the Medical Examiner must be notified at once. death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8567 Gradien Drive 21236 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married mit. Pages I and 2 should be filled within 72 hours after deal utment of Health and Mental Hygiene.

Trant: If fiem 27 is marked orb. 1 Yes Specify: White 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 X No specify: þ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Personal Trainer Fitness 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Spivey Kathy England Be 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Gatewood Mother 8567 Gradien Drive, Perry Hall, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
Dulaney Valley Memorial 1 X Burial 2 Cremation 3 Removal from State Important: I 9/6/2010 Timonium, Maryland Other Specify: 21. Signature of Funeral Service License <sup>22</sup> Burgee Henss of Facility Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** complication failure. List only one cause on each line Between Onset and /Medica Death Cardiac fibrosis and necrosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): ь Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi sician/Medical **X**UNPENDED AMENDED 23a, PII, 27, per ME g910 12/2/10 TT law requires that the death certificate be Box 68760, IE EEMALE 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown Phy P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Cocaine and alcohol use 1 Yes 2 No 3 Probably 4 Unknown Completed of Vital Records, this certificate has been s director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes 2 No 25 Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene 2 ER/Outpatient 3 DOA this 2 No 1 V Yes ဥ 28a. Date of Injury (Month, Day, Year Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Division Director: d in by the f 5 Pending 1 Yes 2 No Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined To the Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

**OCME 2006** 

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month SEP

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Resistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a)

29c License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 31, 2010

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	of Marylan		irtment of tificate of		and Me			7   1   1	)	278	67
			Registrar  1. Decedent's Name (First, Middle,	Last)		001	incate of	Death	:	2. Date of De	Reg. No ath		_	3. Time of	
	Physicia Medic		Frances An	n Sweet					s	Month eptemb	er 2	ž, 20.	ľO	4 12	ΑM
	Examir		4a. Facility Name (if not institution,	give street and nur	nber)		4b. City, Town,	or Location o	f Death			. County of D			
			Transitions nurs 5. Social Security Number	ing Cente	7. Age (In yrs. I	ant hirthday	Sykesv If Under 1 Year		OA Hro I (	Data of Dia		Carrol			
	Funeral Director		212-42-2232	1 □ M 2 □ F	66	Yrs.	Months Day		Min.	3. Date of Bir (Month, Da Jan 31	y, Year) 194	44	Birtnp Co <i>unt</i>	hace (State of try) Mary	1and
7	ow It	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Loc	ation							0d. Inside Cit	tu Limita
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	s 23a Just L	Funeral	1908 Parksley	Avenue			21230				US	SA			
	r item iner n		11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Fo			as Decedent of Yes, specify Cu					14. Race - A Black, W			
20	s after ral", o Exam	d by	3 ☐ Widowed 4 ☒ Divorced	ed 1 🗌 Yes If Yes, Giv Year or D	re .	1	☐ Yes 2 🛣 1	lo Specify:					nit		
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Maryland 21215-0036	iled w I Hygi other vent, t	Be	17. Father's Name (First, Middle, La	st)		1 016	IK	18. Mothe	r's Name (I	First, Middle,	<u> </u>				
<u>Xa</u>	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	P	Frederick Limpe	rt				Mari	e Viz	zini I	imp∈	ert			
Za Za	shou h and 7 is m rraum		19a. Informant's Name/Relationshi			1	g Address (Stree							ode)	
<u>မ</u>	and a Healt tem 2		Evelyn Sweet (D 20a. Method of Disposition	aughter)	20b. F	0422 Place of Dispos	Oakhi11	Drive	, Syk			1D Z1/0 ocation - City		wn State	
Ē	Page 1 ment of ant: If i		1 ☐XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		State	emetery, crem	atory or other p dra1 Ce					Baltimo			
Baltımore,	permit. Page 1 a Department of B Important: If it any injury or of		21. Signature of Funeral Service Lig		<b>#</b> .		Name and Add Box 19								
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			23a. Part 1. Enter the disease, or of shock, or heart failure. List on Immediate Cause (Final	ly one cause on ea	caused the deat ich line.	h. Do not ente		4			rest,			Approximate Interval Bety Onset and D	ween
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POX	death ce he attend ed for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 🗌 Live	come of pregna Birth 2  Feta nant at time of c	al death 3 🗌	Ectopic pregna	ncy				23d. Date of Month		,	/ear
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ַ ס	ling Ph		27. Manner of Death  Part Natural 5 Pending	28a. Date (Mon	of injury th, Day, Year)	28b. Time of injury	28c. Inj wa	ıryat rk?	286	d. Describe h					
SIO	death ctor: / ctor: / y the i	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	ot be	of Injury - At ho	me, farm, stre		Yes 2 🗆	-	f Location (S	Street and	d Number or	Rural I	Route Numbe	er
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	In the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  within 24 hours after death.  To the Funetal Director. After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as	Medical		Physician: To the base											nner stated.
	ithin 2 of the Formplet	Me	only one) 8 Certifying N 29b. Signature and title of certifier	lurse Practioner:	To the best of my	y knowledge, de	eath occurred at	the time, date	and place,	and due to th	e cause(s	and manner	as sta	ted.	mor orgicou.
	- ≥ <b>-</b> ĕ		1/M2				De	1777	_<		Zau. Dat	te signed (Ma	1	)	
	ね		30. Name and address of person w			23a) (Type, Pr	int)	312	<u>, , , , , , , , , , , , , , , , , , , </u>		1 .		~	( D	
	J_		31 Date filed (Month Day Your	Hmoo		7, Ki	uge K	ord	~	45/m	Ins	18	2	115	7
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marvel Spencer 2010 September 4:30  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7205 Chestnut Street Chevy Chase Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth Months Days Hours Min. (Month, Day, Director 579-14-7555 91 Yrs. July Washington, D.C Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Manyland 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery 1X Yes 2 □ No Chevy Chase 10e. Street and Number 10g. Citizen of What Country? Funeral 7205 Chestnut Street 20815 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 X No by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working marked other than matic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Secretary National Institutes of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harry Bien Marie Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Spencer/Husband 7205 Chestnut Street, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any injury or o 1 Durial 2 X Cremation 3 Removal from State September 7, 4 Donation 5 Other (Specify) 2010 Bethesda, Maryland Robert A. Fumphrey Funeral Home Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licens M01530 Haron 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death aAlzheimers Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? ☐ Pregnant at time of death ☐ Unknown Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 🗓 No 1 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 🗓 No ဂ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Records, P.O. Box 68760 Hospital or Attending Physician: The law requires Division of Vital in 24 hour. the Funeral Direc. within 2 To the I

State Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier

(Check

only one)

3

Timothy L. Krohe,

29b. Signature and title of certi

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

44290

6900 Georgia Avenue, NW, Washington, D.C. 20307

29d. Date signed (Month, Day, Year)

September 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lend #12 Per FH G907 9/17/10 Jh
State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 27869 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 1, Anthony John Stemski 20<sup>4</sup>10 8:30 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15300 Diamond Cove Terrace #4 Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days Months Hours March 31, 1943 089-34-7969 New York 67 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Montgomery Rockville 1 X Yes 2 No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be Funeral 20850 15300 Diamond Cove Terrace #4 United States hours after death 12. Was Decedent Ever in 6.2 -Armed Forces? 196.2 -1 🖾 Yes 2 🗆 No 69 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1966—1973 1 ☐ Yes 2 🖾 No Specify: "natural", Completed 3 Divorced 4 Divorced Specify. White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Network Administrator Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt.
Department of Health and Mental I Important: If item 27 is marked o any injuy or other traumatic evene. ဂ John Conrad Stemski Margaret Ranken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Stemski/Wife 15300 Diamond Cove Terrace #4, Rockville, MD 20850 Baltimore, Date 9 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
All Souls Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Sept. 2010 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Frieral service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alcoholic Cirrhosis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? ģ Day Year Pregnant at time of death detached f 9 Unknown g Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Emphysema 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Malnutrition 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autopsy performed? Yes 2 K No hours after death.

uneral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 A Residence 6 Other (Specify, filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Nat*u*ral 5  $\square$  Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F 3 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) D35370 September 1, 2010 30. Name and address on who completed cause of death (Item 23a) (Type, Print) 17325 Rockville Pike, #104, Rockville, Maryland 20852 Backowski M.D. 32. Regis State 20 Registrar △ DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 581 . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2711 DELK CT DUNDALK BALTIMORE 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F (Month, Day, Year) Months Days Hours Min. Country) Director 213-52-3709 2-01-47 Usual Residence of Decedent 28a-f shov 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits MD BALTIMORE DUNDALK 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2711 DELK CT. items 23a 21222 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian ō by 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural", Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OFFICE CLERK BALTIMORE COUNTY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit, Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ GEORGE M. PARRISH RUBY EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD E. STOKES/HUSBAND 2711 DELK CT., DUNDALK, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ON SITE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 09-09-10 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ neumon disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** mo Sequentially list conditions, Examiner If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for de a consequence on and I-transit The law requires that the death certificate be executed g physician are the burial-t resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 2 No signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate | Yes 2 the Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident Investigation 1 ☐ Yes 2 ☐ No Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Dag, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

ar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Year SEPTEMBER CLAIRE **SCHULMAN**  $A^{M}$ 8:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FOREST HILL HEALTH AND REHABILITATION FOREST HILL HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month Day, Year) 06/19/1930 Director 191-22-5595 PENNSYLVANIA 80 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medi-al Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits FL SEMINOLE 1 Yes 2 No WINTER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 362 TWELVE OAKS DRIVE UNITED STATES 32708 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ Yes 2 □ No Specify: 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White STE ģ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 3

▼ Widowed 4 □ Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 YEARS HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ALBERT RABINOWITZ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. FRANCES LEVINSKY other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, BRYAN SCHULMAN / SON 362 TWELVE OAKS DRIVE, WINTER SPRING, FL 32708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State KING PAYID MEMber PARK 09/05/2010 BENSALEM, PA 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Lice SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD BALTIMORE, MD 21208 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner V23 Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -transit Hospital or Attending Physician: The law requires that the death certificate be executed Exam O der and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month g 🗌 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 2 No 1 ☐ Yes 2 [ 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 🗌 Yes 2 10 Other: this 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural s after death. 1 🗌 Yes Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR DAVID DUNN 615 W MACPHAIL ROAD BELAIR MD 21014

W DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 0 9 0105 SCHAD 05 FUELYN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Encore at Turf Valley Ellicott\_City Howard 5. Social Security Number If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F 88 Director 216-12-0909 June 22, 1922 Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Md. Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be 8800 Walther Blvd. #1015 21234 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. ş Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker Own Home 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fill hand Mental H 7 is marked oth William Herbert Cypull Helen Klutch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any Injury or other traurr once. Mr. Richard S. Schad/ Son 10013 German Rd. Ellicott City, Md. 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 9-9-10 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name Rucker Towson Funeral Home, Inc. 21. Signature of Funeral Service/Licens 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEMENTIA disease or condition resulting in death) moruis /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examiner Due to (or as a consequence of): that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a Box 68760, Physician/Medical as guipt 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery for us 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a Ö 9□Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by vesculer pheral 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No has page to thrive certificate Jailure 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Maprier of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? e Hospital or Attending PI 124 hours after death. e Funeral Director: After the letely filled in by the funeral 28b. Time of 28d. Describe how injury occurred After 1 Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours aff To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 09 05 2010 00053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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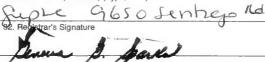
State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

SFP 0 7 2011

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens for State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Month Year Jean Smith-Groomes 6:05 AM 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hos Soitol 7. Age (In yrs. last birthday) Baltimore Roseda | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 2 Pay, | Social Security Number 9. Birthplace (State or Foreign Country) Maryland **Funeral** 217-26-3969 <sup>ve</sup>1930 1 □ M 2 1 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It. Modical Evaning in ust be notified at one. 28a-f show 10d. Inside City Limits Director Maryland Baltimore. Baltimore 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3907 Hannon Court Apt. 2A 21236 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐XNo
If Yes, Give
Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Joseph Anthony Rose ပ Stransky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Compher/ Friend Grayson Place Sterling, Virginia 20164 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 9/4/2010 Towson, Maryland 21. Signature of Fun and Secure Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jesus or Irjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 15 No Day Month Year 5 Other (specify) P.O. ned by the a detached f 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Pneu 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After Certification: 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending after death.

I Director: Af din by the fur investigation 1 ☐ Yes 2 ☐ No 3 Sulcide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37612 9-3-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Mohamad Alabrash 9000 Franklin Square Drive Baltimore, MD 21237
31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Smith-Groomes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) SCHENNING **Physician** 0550 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner NOPKINS PAYVIEW CARE LENTER
by Number 6. Sex 7. Age (In yrs. last birthday) BALTIMORE Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 12-16-1921 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1 M 2 XF Director Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show Baltimore 1 X Yes 2 □ No **Funeral Director** Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with U.S.A. 21224 3802 Fait Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: pērmit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items: any injury or other traumatic event, the Medical Evarance once. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 ☐ Married imore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be John Rebbel Elma 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7007 Fait Avenue Baltimore, Maryland 21224 Patricia Esposito -20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 9-9-2010 Sacred Ht of Jes. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 21. Signature of Fugeral Service Licenses 263 S. Conkling St. Balto. Md. 23a. Part 1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertension /Medical Due to (or as a consequence of): Examiner 38 years etva locu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine (al or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 KNo Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No Stroke 24a. Was an autopsy perform 2 12 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Matural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certified 1538365168 2010 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT MINETE 5505 NORKING BRYLLEW C 550'S NOFKING BAYLEN CIRCLE BALTIMOLE MO 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Julian Timm 2010 6:12 August D Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 30613 Pine Knoll Road Somerset Princess Anne Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Days Hours April 24 Year Pennsylvania 56 Director 176-46-5253 1954 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Knoll Road 30613 Pine United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 \( \square\) No unk Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. White "natural" Completed 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical lonce. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)  $\overset{\text{Elementary/Seconday (0-12)}}{12}$ College (1-4 or 5+) Machinist Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Timm Marie Luciano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2530 South 15th Street, Philadelphia, PA 19145 Marie Cox. Friend 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗆 Burial 2 🖺 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/2/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ BLEFDING disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and I-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🔲 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: A/
pmpleted filled in by the ft. 1 ☐ Yes 2 ☐ No Accident Investigation ∴ Accider
 ∴ Suicide
 ∴ Suicide
 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and place and the cause(s) and manner as stated. Medical 29a. Certifier Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D ASD98 12010

DHMH 17 Rev 7/2009

State Registrar Hall Highway, Crifield MD 21817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kaumbunakan

32. Regi

iay

Year

31. Date filed (Month, Day

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	aryland	_	irtment of H		and Mer		iene 201	0 27	876
			negistrar     Name (First, Middle, La	st)			outo of 2	- Cuiii		Date of Deatl		3. Tim	ne of Death
	Physici		Edward	4		111	104			Month WSAS+	2°6 2	Year 010 9	: 07AM
Y	/Medi Examir		4a. Facility Name (If not institution, give	re street and number)			4b. City, Town, or	Location of		0	4c. County o		<u>'</u>
			The Johns Hopkins H				Baltimore					_	
1392 - 27 - 27	Funeral Director		5. Social Security Number 105–28–1493	Sex 7. Ag	e (In yrs. Ia 73	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day, 3/20/3	Year)	Birthplace (State Country)	ate or Foreign
	pu »		Usual Residence of Decedent  10a. State 10b. County		10a City	Town or Loc	ation					10d Ingie	de City Limits
	e Maryla <b>3a-f sho</b> v ified at	ctor	NY Ki	ngs	Toc. City	, fowil of Loc		3rook1	.yn				Yes 2 No
	with the	al Director	10e. Street and Number 61 Oliver Stree	et (4c)			10f. Zip-Code	209		10	0g. Citizen of Wh	nat Country? USA	
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  To fleath and Mental Hygiene.  To ther 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba	spanic Orig n, Mexican, Specify:	gin? (Specify Puerto Rica	Yes or No- in, etc.)		American Indian White, etc. white	n,
21215-0036	hin 72 ho  In "natura Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		i+)	(Give I	ent's Usual Occupa kind of work done of OO NOT use retired,	during most	of working		16b. Kind of Bus	iness/Industry	
21	ed with giene. er thai	Com	12	1			Consulta					Computer	s
land	ould be filed of Mental Hygis larked other attc event, the	To Be	17. Father's Name (First, Middle, Last, Francis S.						r's Name <i>(Fi</i> . <b>orenc</b> e		Maiden Surname len	)	
Σ	1 and 2 should I Health and Meni em 27 Is marke other traumatic e		19a. Informant's Name/Relationship (Danielle F. T		e		g Address (Street & Oliver S					tate, Zip Code) 11209	
a)	permit. Pages 1 ar Department of Hee Important: If item any Injury or othe once.		20a. Method of Disposition 1 → Burial 2 → Cremation 3X 4 → Donation 5 → Other (Speci	fy)	Gr	emetery, crem Ceenwoo	sition (Name of latory or other place od Cemete		9/1/2	,	20c. Location - C		
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licer	See Victor P	. Doc	la , 22 Cl 1:	Name and Address Darles L. 501 E. Fo	s of Facility Stev rt Av	ens Fi	neral Baltir	Home, Ir	nc. 21230	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.	Do not ente	er the mode of dying	g, such as	cardiac or re	espiratory arre	est,	Approx	imate Between
F	hysician		Immediate Cause (Final disease or condition	. Mult	Sui	sten	1 019	jan	ta	iluva	2	Onset a	and Death
	/Medical Examiner		resulting in death)	Duè to (or as	a conset u	ence of):							
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	ed sit	Examine	5 agus Itally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence or):							
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	ifficate g phy as the		JE 55144.5										
O. Box	I ne law requires that the death certifics te has been signed by the attending pt page 2 should be detached for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)	′			23d. Date Mont		Year
O.	ed by detac	by Pl	Part II. Other significant conditions	contributing to death b	ut not resu	Iting in the u	nderlying cause giv	en in Part I		23e. Did tob	acco use contrib	oute to the cause	of death?
rds	w requires tha been signed I should be de									1 🗌 Ye	s 2 No 3	Probably 4	Unknown
Division of Vital Records,	ne faw requ thas been age 2 shou	Completed			-					24a. Was an autopsy perform	v pr	ere autopsy findi ior to completion eath?	ngs available of cause of
<u>ta</u> '	sician: Tr certificate irector, pa	BeC	25. Was case referred to medical			_		26. Place	of Death (Ch	eck only one		00	
<b>&gt;</b> :	nysici is cer I direc	10 1	examiner? 1  Yes 2 No	Hospital: 1 Inpatie	nt 2 🗆 E	R/Outpatient	3 □ DOA Othe	er: 4 🗆 Nur:	sing Home	5 🗆 Resider	nce 6 🗆 Other	(Specify)	
ion o	or Attending Physician: after death. Director: After this certifice in by the funeral director.		27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day n	Y Year)	28b. Time of Injury	28c. Injury Work M 1 🔲	rat ? ⁄es 2 □ N		Describe ho	w injury occurred	d	
Divis	al or Attend s after death   Director; A ed in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of inju building, etc		ne, farm, stre	et, factory, office			Location (Sti Cify or Town,	reet and Number State)	r or Rural Route	Number,
:	or the hospital or Artending Prysteran: The inwithin 24 hours after death.  To the Funeral Director, After this certificate ha completely filled in by the funeral director, page	edical	(check only 2 Medical Exa	nysician: To the best o miner: On the basis of and manner sta	examination								use(s)
	Vithii To th COMP	Me	29b Signature and title of patifier	× ()	~		29c. License		34	29	d. Date signed (	Month, Day, Year	
			MANX	AX	7)	)	RES	3-(	200	A	Lugust	26 20	010
4			30. Name and address of person who	completed cause of d	eath (Item	23a) (Type, I	Print)		-14 000		60 Ct D-11	imana 141	D 0400=
	Sta	to	31. Date filed (Mock) Pay, Year, 10	32 egistra	r's Signatu	14.1.	a Kal		OUU NO	111 4401	fe St, Balt	imore, Mi	D, 2128/

Registrar

DHMH 17 Rev 1/2001

10-06538 June Taylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene 2010 27877

		1- For State Registrar	Cen	tificate of De	eath	Re	g. No.	
Physici		Decedent's Name (First, Mide	dle,Last)			2. Date of Death Month	Day Year	3. Time of Death
Medical Exami	iner	June	laylor	1450	. T	August 30,		0751 hrs
		4a. Facility Name (if not instituti 1330 Laurens Street			ity, Town, or Location of De altimore	atn	4c. County of Deat	7
Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. la		Inder 1 Year   If Under 24	Irs. 8. Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or
Director		213-54-3251 Usual Residence of Decedent	1□M 2⊠F 60	Yrs, M	onths Days Hours M	June	Forei	
any		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	_	Mod N	1A B	altin	mre.			1 Yes 2 No
Maryland 28a-f show 1 at once,	ectc	10e. Street and Number	AI	pt, 10f	Zip Code	10	g. Citizen of What Cou	intry?
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once	Funeral Director	1330 La	urens St. 1	09	21217		USF	
eath wi items	nera	11. Marital Status 1 Never Married 2	12. Was Decedent Ever in U.S Armed Forces?		edent of Hispanic Origin? ( pecify Cuban, Mexican, Pue		14. Race - Amer White, etc.	rican Indian, Black,
fter de l'', or		3 Widowed 4 Di	1 Yes 2 No ivorced If Yes, Give Year	1 Yes	2 No specify:		Specify: 2	Inck
ours a	d by	15. Decedent's Education (Sp	ecify only highest grade completed)		ual Occupation (Give kind o		16b. Kind of Business	Industry
27 3	olete	Elementary/Secondary (0-12	) College (1-4 or 5+)	during most of	working life. DO NOT use r	etired)	0.	1. 0.
21215-0036  Montal Hygiene. marked other than "natural", c event, the Medical Examiner	Completed	17. Father's Name (First, Middle	a Last)	CIE	18 Mother's Na	me (First, Middle, M	Private Sumame)	Te Co.
21215- uld be filed Mental Hy marked of c event, th	Be C	Grant	Taylor		Tace	Lun T	Covir	aton
1 2 2 2 2	70	19a. Informant's Name/Relation	ship (Type, Print) (daughted	19b. Mailing Add	ress (Street and Number of	or Rural Route Numb	er, City or Town, State	o, 20 Code) 2(23/
MD d 2 sho dth and n 27 is		Ms.Latawr	ria Taylor	924 V	Nashingt	on BI	vd. Balt	D.Md.
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N Important: If iten 27 is n injury or other traumatic		20a. Method of Disposition  1 X Burial 2 Cremation		lace of Disposition ( rematory or other pl		Date /7/20	20c, Location - City or	Town, State
Baltimore, Permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other S		rrison	Forest "	7/2010	Owings	Mills,Ma
Baltimo permit. Page: Department o Important: injury or oth		21, Signature of Funeral Service	e Licensee	Jose Jose	and Address of Facility	Funeral	Home P. I	A f
Physician			r complications that caused the death.	Do not enter the mo	de of dying, such as cardia	or respiratory arres	st, shock, or heart	Approximate Interval
Model		fail fe. List only one cause Immediate Cause (Final disease	I be a series of the series of the series of the	rotic Cardiovas	cular Disease			Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequence of)					
	اۃ	Sequentially list conditions, if any, leading to immediate	b.  Due to (or as a consequence of):					
	nin.	cause. Enter Underlying Cause (Disease or injury that initiated						
ed nsit	Examiner	events resulting in death) Last	Due to (or as a consequence of):	:				
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760, ficate be g physicia the buria	Medical	IF FEMALE:	23c. If yes, outcome of pregna	ancy			23d. Date of deliver	<u> </u>
certificanding passe as th	- 1	23b. Was decedent pregnant in t past 12 months?	the 1 Live birth	2 Fetal de	ath 3 Ectopic preg	nancy		Day Year
P.O. Box 68: that the death certifine ned by the attending detached for use as:	Physician	1 Yes 2 No 9 V Un	uknown 9 Unknown	th 5 Other (	Specify)		1	
D. B tr the d by the		Part II. Other significant condi	tions contributing to death but not res	sulting in the underly	ving cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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of Vital Records, P.C ing Physician: The law requires that After this certificate has been signed funeral director, page 2 should be det	Completed					24a. Was ar autopsy		atopsy findings available completion of cause of
eco he law ite has	E C					perform	ed? death?	
A. T. T. Barring Straining	ادہ	25. Was case referred to medica	al		26.Place of Death (Chec			
Vita hysici this o	TO B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 E	R/Outpatient 3	DOA Other Nurs	sing Home 5 R	esidence 6 🗸 Othe	r: Scene
J of ding P After funera	Ë	27. Manner of Death  1 ✓ Natural 5 Pen	(Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred	
Sion Attended death rector: by the	cati	= 7 Pen	estigation	no form street fool	1 Yes 2 No	206 Lagatina (Ch	and and Northern on Di	and Doute Sharehor City
Division of Vital Records, P.O. pital or attending Physician: The law requires that thours after death.  teral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	dete	ald not be 28e. Place of Injury - At home (Specify)	ne, rarm, street, rac	ory, office building, etc.	or Town, Sta		ral Route Number, City
Hospi 24 hour Funer rely fil		4 Homicide  29a. Certifier 1 Certifying P	hysician: To the best of my knowledge	e, death occurred at	the time, date and place, a	nd due to the cause(	s) and manner as stat	ed.
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	one) 2 Medical Exa	aminer: On the basis of examination and and manner stated.	d/or investigation, in	my opinion, death occurred	d at the time, date ar	id place, and due to th	e cause(s)
	Σ	29b. Signature and title of certifi	er / mi		29c. License number		29d. Date signed (Mo	
		Allen pro	in (, 112)		O.C.M.E.		August 30, 2010 	
N		<ol> <li>Name and address of person Melissa Brassell, MD</li> </ol>	n who completed cause of death (Item 2 Assistant Medical Examine		Street, Baltimore, MI	D 21201		
St	ate	31. Date filed (Month, Day, Year)						
Regist		\$ED 0 7 2010	1 1 2					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rea. No. Death

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			. For		State o	f Marylan	d / Depa	artment of H	lealth and	Mental H	lygier
			1 - State Registrar				Cer	tificate of L	<b>Death</b>		Reg. N
	Physic	ian	1. Decedent's Nam	ne (First, Middle	e, Last)		Tex	tor		2. Date of Month	ch 7
	/Medi			If not institution	, give street and num	nber)	101		Location of Death	100	11 3
	Exami	ier	The Johns					Baltimore	City		
700	Funeral Director		5. Social Security 1 161–56–046	Number	6. Sex 1 💢 M 2 🗆 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of 1 (Month) 06/14	Day, Year
	ъ.		Usual Residence o								
	f show	JO.	10a. State	10b. County	hous		, Town or Lo				
	the N	Director	PA 10e. Street and Nu	Lancast	.er	MITIO	ow Stree	10f. Zip-Code			10g. 0
	h with 23a or st be r		410 Beaver		Pike			17584			U
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Mari 3 □ Widowed	ried 2 🗌 Marri	12. Was Dece Armed Fo	2 <b>X</b> No		Was Decedent of H f Yes, specify Cuba □ Yes 2 🕱 No	lispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or to Rican, etc.)	No-
21215-0036	hin 72 hou In "nature Medical E	Completed	(Spe		t's Education st grade completed)	-4 or 5+)	(Give	fent's Usual Occup kind of work done o DO NOT use retired	during most of wor	rking	16b.
21,	d with giene ar tha the I	Son	12				Owner				Har
	be filed tal Hygid d other event, ti	Be (	17. Father's Name	(First, Middle, I	Last)				18. Mother's Nar	me (First, Mide	dle, Maid
<u>a</u>	uld b Menta Irked tic e	2	Raymond		Texter				Betty		Jane
Maryland	d 2 should be filed within the and Mental Hygiene. 27 is marked other than traumatic event, the Me	11. 12	19a. Informant's N Raymond Te				Ī	ig Address (Street precher Roa			
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra		20a. Method of Dis 1 [X Burial 2	position  Cremation	3 Removal from		lace of Dispo	sition (Name of natory or other place		Date	20c.
Ē	. Рас ment tant: jury (	,		5 Other (S)		Wil:		Mennonite		3/2010	W
Balt	Departiment Import		21. Signature of Fu	ineral Service L	icensee			. Name and Addre		Leonard	J. Ru

White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Harley Davidson Lancaster **Owner** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Texter, Father 55 Sprecher Road Willow Street, PA 17584

20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Willow St. Mennonite 09/03/2010 W. Lampeter Two.

21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 Dan

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of)

Due to (or as a consequence of)

IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death in the past 12 months?

2 No 9 Unknown 9 Unknown

Pregnant at time of death 5 Other (specify)

3 Ectopic pregnancy

RES-000

Day Month

Yes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 2 🗆 No 1 Yes

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

2010 4c. County of Death N/A

10g. Citizen of What Country?

Specify:

Race - American Indian, Black, White, etc.

U.S.A.

 Birthplace (State or Foreign Country) PA 10d. Inside City Limits 1 Yes 2 XNo

Aument

Approximate Interval Between Onset and Death

Year

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 🗆 DOA

28a. Date of Injury
(Month. Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 🗌 Yes 2 No

2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of sertifig 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

50

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once.

**Physician** 

/Medical

**Examiner** 

and

attending physician a for use as the burial

the

þ

has t

certificate director, peg

this

within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur

Hospital or Attending Physician: Te law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

Completed by

Be

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Certification:

Medical

State

Registrar

Kaymond 31. Date filed (Month, Day, Year) SEP 0 7 2010

examiner?

27. Manner of Death

1 Natural

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Pare of Marylahc9/Department of Health and Mental Hygiene 1 - For State Registrar 27879 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Murle Lee Thompson 18:31 M 08 30 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Agnes HOSPItal If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 □ F Yrs 215-32-2861 89 Director July 18, 1921 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiene. Intent of Health and Mental hygiene. Intent if item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, its Modical Exmitime mast be notified at any or other traumatic event, its Modical Exmitime mast be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 ☐ No Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2215 Maiden Choice Lane 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 TNo Specify Specify: Ş Q White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture 9 Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harvey Thompson Edith Ridgley ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Mrs. Doris Mary Thompson (Wife) 2215 Maiden Choice Lane, Catonsville, MD 21228 Department of Health Important: If item 27 any Injury or other troone. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 9/2/2010 Marriottsville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses M00764 Hayl PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): 5 days Examiner Pheumonia - Ventilator dependent Sequentially list conditions Physician/Medical Examiner it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Mellihus Diabetes the burial-tran Due to (or as a consequence of) attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Hinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I **À** 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed? Yes 2 No page 2 1 🗌 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MARSON MOVIC Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours after deat Funeral Director: completely within 2.

3altimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

Nath

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOM

29c. License number

P25498

29d. Date signed (Month, Day, Year)

30/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27880 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Tate Hospice House Linthicum Anne Arundel Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Hours Min. Sept. 2, 1929 1 □ M 2 N 220-26-9613 81 MD Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Anne Arundel Glen Burnie MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 907 Nunnally Way U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Payroll Clerk Federal Government permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, til ones. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Robertson Edith Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8213 Millfield Court Millsville MD 21108 Mr. Daniel Galley /POA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 9, 2010 Brooklyn Park, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie MD 21061 an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer set and Death Immediate Cause (Final APPENDICE Physician/ monte disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -transit the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last ng physician ar as the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No for Pregnant at time of death 9 I Inknown g Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown GRANULOMATOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 No ၉ 4 Nursing Home 5 Residence 6 Dother (Specify) TATE ITOUSE 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certif

31. Date filed (Month, Day, Year)

ss of person who completed cau

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ate of Death nt's Name (First, Middle Physician/ Medical Name (if not institution, give street an 4b. City, Town, or Location of Death **Examiner** lowson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours 1 🗆 M 2 🔀 F Director 219-66-5292 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at Directo 1 Yes 2 No MMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 No Black, White, etc. δ 1 Never Married 2 Married 1 🗆 Yes 2 🔀 No Specify If Yes, Give 3 

Midowed 4 □ Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) conday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State Page 1 a permit. Page 1 a Department of I Burial 2 Cremation 3 Removal from State Donation 5 Dother (Specify) . Signatule of Funeral Service Indensee tunera +more 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER disease or condition resulting in death) years Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is interested as or its first of the control of the contr Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No signed by the atte Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 🗌 Yes Be 25. Was case referred to medical funeral director 26. Place of Death (Check only one) 2 No Other: 1 Yes ည ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 1 Inpatient 2 I After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5  $\square$  Pending 1 Yes 2 🗆 No Accident Suicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature, 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mor.

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State	State of M	laryland		rtment of <i>ificate o</i> a	Health and	Mental H		2010	27882
		Registrar  1. Decedent's Name (First, Middle,	Last)		Cert	incate of	Death	2. Date of D	Reg. N		3. Time of Death
Physicia Medic		RONALD W	• • • •	1001				Huo	1 9	29 2010	7:00AM
Examin	er	4a. Facility Name (If not institution,	give street and number)	-00 t	_	4b. City, Town	or Location of Deat of Himo		4	c. County of Deat	th
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. la		If Under 1 Ye	ar If Under 24 Hrs	8. Date of E	Birth Da <i>y, Year</i> )	9. Bir	thplace (State or Foreign
Director ≥		Usual Residence of Decedent		34	Yrs.			Apr	29	1954	7110
uryland a-f sho fied at	Director	10a. State 10b. County		10c. City	Town or Loca	• •					10d. Inside City Limits 1   Yes 2 □ No
the Ma r or 28 se notii		10e. Street and Number			Jair	10f. Zip Code			10g. C	Citizen of What Co	
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The and Mental Hygiene.  The part marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral		12. Was Decedent	eet	12. W	a Doesdort e	21229	nosify Von er N	<u></u>	<u> </u>	SA
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1 and 2 of Healt item 2 other		20a. Method of Disposition	es c vaugr		7080 (ace of Disposi	tion (Name of	erock M	Date Hy		026 Col Location - City or	umbia MD 21649 Town, State
permit. Page 1 and Department of Hea Important: If item any injury or othe once.		1   Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Sp	pecify)	_ /	emetery, crema Laon	Par	K 9-1	4-10	Bo	altimor	e, MD
permit. I Departm Importa any inju once.		21. Signature of Funeral Service Lic	ensee A Con C		₹0	Name, and Add	dress of Facility Greene	uneral	Se	vice 2	1229
		23a. Part 1. Enfor the disease, or of shock, or heart failure. List on	complications that cause	d the death	. Do not enter	the mode of d	ying, such as cardiad	or respiratory	arrest,	1100	Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. CAN	CEY	2, Me	etasta 1	he				Onset and Death
Examiner		1	Due to (or as	a conseque	ence oi):	Cano	er				
sit of	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of):						
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	Physician/Medical	8	d								
eath certifica attending pl d for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of de	livery
requires that the death certificate be been signed by the attending physic should be detached for use as the bi	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1  Live Birth 4  Pregnant : 9  Unknown			Ectopic pregna Other (specify)			-	Month	Day Year
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requires t been sign should be	Completed by	DIABETES	MEU	TUS,	Expe	2		1₽⊑	Yes 2	2 □ No 3 □ P	robably 4 🗆 Unknown
	nplei							24a. Wa	s an opsy formed?	24b. Were au prior to death?	topsy findings available completion of cause of
ician: The law certificate has I rector, page 2 s		25. Was case referred to medical				26.	Place of Death (Che	1 🗆 Ye	s 2 2 1		s 2 □ No
	To Be	examiner? 1  Yes 2 No			ER/Outpatient	_ [	)ther:		sidence	6 ☐ Other (Spec	ify)
ding P th. After tl funera	cate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga		ury ay, Year)	28b. Time of injury		jury at ork? □ Yes 2 □ No	28d. Describe	how inju	ury occurred	
r Atten ter deat rector: by the	Certificate:	3 Suicide 6 Could not determine	ot be 28e. Place of Inj	ury - At hor					(Street a		ral Route Number,
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di		29a. Certifier 1 Certifying F	Physician: To the best o			cured at the ti	me date and place				ated
he Hos in 24 h he Fun ipleted	Medical	(Check 2 Medical Ex	aminer: On the basis of o	examination	and/or investig	ation, in my op	inion, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated.
Noth To t		29b. Signature and title of certifier	2 /-	,		29c. Lice	nse number		29d. D	ate signed (Month	n, Day, Year)
01		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type, Pri	nt)	133/9		5	[ / [ / ] ]	3
10.		4538 Edm.	ndron Aven	ve 1	Bolhi	none	MO "	2122	91	VEIL	M. SIECEL MY
Stat Registra		31. Date filed (Month, Day, Year) SEP 0 7 201	O Agenti	rar's Signatu	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ٥١٥٥ ماۋر 16:09 PM Physician/ September Martina Marie Wagner Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Baltimore Social Security Numb If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months May 23, Year 1936 1 □ M 2 🔀 F 74 Yrs. New York 218-32-5919 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nortified any injury. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No <u>Mar</u>yland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 817 Hampton Lane 21286 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🕅 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 
Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ years Educator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Alphonsus Wagner Eloise Consuela Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 N. Charles Street Baltimore, Maryland 21212 Sr. Bernadette Walsh, S.S.N.D. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Green Mount Crematory 9-3-10 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, Mary 21212 23a. Part 1. Eruer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ pneumonitis, undeterminal cause disease or condition resulting in death) 40ars Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Breast nsitu 2 No 3 ☐ Probably 4 ☐ Unknown Mnomboemboli 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 1 Tyes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 24063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Ave. Baltimore, MD 21229 Shannarose Guma

DHMH 17 Rev 7/2009

State Registrar

agney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20**1**0 5:50 PM Boyd Wood Sept Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 715 Fuselage Avenue Middle River If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug 20 South Carolina I944 251-72-2112 66 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? Funeral 21220 715 Fuselage Avenue USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner is Black, White, etc. 1 Never Married 2 XMarried Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Owens Dorsey Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Fuselage Avenue Middle River, MD 21220 Susan Davis-Wood, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 09/07/10 Metro Crematory Inc. : Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor roman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final set and Death Ni Ph\_sician/ disease or condition Medical resulting in death) Examiner 192 Salumidity list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?

1 Yes 2 No for Month Day Year 5 Other (specify) the detached 9 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed certificate 2 🗆 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation M 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Hospital Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 0 armi cause of death (Item 23a) (Type, Print 30. Name and address of person who completed Dre ARNI NID 20 ARI 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2010 3 AM M Muni Weisman Herman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 14631 Deerhurst Terrace Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth Funeral Hours 12/21/1916 Russia 93 Director 471-18-2796 Usual Residence of Decedent items 23a or 28a-f shov 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Examiner must be notified at Director Silver Spring MD 1 ¥ Yes 2 □ No Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20906 United States 14631 Deerhurst Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give ve 1943-Black, White, etc. ō 1 Never Married 2 Married þ Maryland 21215-0036 White 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates. the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) College Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rebecca Gailerman Abraham Weisman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maple Grove, MN 55311 Page 1 and 2 sh ment of Health a ant: If item 27 is Lise W. Duran - daughter 14602 64th Avenue North Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/07/2010 Olney, MD Judean Mem. Gardens Danzansky-Goldberg Memorial Chapels Inc II/O Rockville Pike Rockville MD 20852 21. Signature of Funeral Se M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure
Due to (or as a consequence of): disease or condition resulting in death) Medical **Examiner** Aspiration Pnuemonia Sequentially list conditions, light cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consuluence of attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No signed by the a d be detached f g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death. cate has b page 2 s autopsy performed? Yes 2 No certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 2**X** No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) mee D37801 September 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aimee Jane Seidman MD 15020 Shady Grove Road #300 Rockville, MD 20850 31. Date filed (Month, Day, Year, 32. Registrar's Signature State SEP 0 7 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WHITTINGTON, JR. Physician/ Month Da Year ARTHUR 2:57 AM AUGUST 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE WASHINGTON MEDICAL GLEN BURNIE HRUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 21, 1922 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 X M 2 - F Months Mary Land **Director** 213-18-3953 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🗆 Yes 2 🗓 No Maryland Anne Arundel Linthicum 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21090 514 Cheddington Rd. United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 Never Married 2 X Married X Yes 凶Hrtr・NGToN , AKTもの Raltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Store Owner Office Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Arthur H. Whittington, Sr. Annie Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl Whittington / Wife 514 Cheddington Rd. Linthicum, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 A Burial 2 X Cremation 3 - Removal from State Metro Crematory 4 Donation 5 Other (Specify) 9/2/2010 Catonsville, Maryland 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy. SE; Glen Burnie, MD 21. Sign ture of Pineral Se ite Licanee 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ neumon disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. within 24 hours after death. **To the Funeral Director.** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Great 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Curtifying Nurse Practioner To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number Critical Care Physician Medical Center, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie MD 2016) Baltimone Washington Patel MD Kalpesh 2. Registrar's Signature 31. Date filed (Month, Day, Year) 7 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Sept. 201°0 5:35 Merlene G. Wilkerson AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🎛 F July 31 19-09-Maine Director 96 ",1914l Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Baltimore Sparks 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral P.O. Box 505 21152 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 Yes Maryland 21215-0036 white 1 ☐ Yes 2 K No Specify: Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 12 should be filed within 72 lath and Mental Hygiene.
127 is marked other than "refraumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Interior Design 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Clarence Gile Maude Gile permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic or 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1931 Old Annapolis Road-Woodbine, Maryland 21787 Sandra Ellington-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Immanuel Episcopal Church Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sept.4,2010 Glencoe, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Figure Fineral Chapel and Chemation Services 16924 York Road-Mankton, Maryland 21111 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequenc Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of imjury that initiated events signed by the attending physician and a betached for use as the burial-tranresulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day 1 | Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been s 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No has prior to completion of cause of death? certificate 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital (<u>P</u> 2 NO No Other: 1 🔲 Yes MOSPUL 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my animal. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M Chances UMMURI 6701 TUNISON 31. Date filed (Month, Day, Year) State SEP 0 7 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Margaret E. Wills Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗙 F Months Days Hours Min. 212-28-6663 89 Director Maryland Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** Baltimore County Catonsville Maryland 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 20 10g. Citizen of What Country? 21228 1206 Edmondson Avenue items 23a United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 5 þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SuperFresh Cashier N/A traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I important: If item 27 is marked o any injury or other traumatic events. n and Mental ၉ Clarence E. Johnson Eleanore L. Gount 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3634 Foxmeadow Court, Jarrettsville, Maryland 21084 Charlene Ziemann (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 2010 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland Evans Funeral Chapel Sept. 3, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 & celt or 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause Disease or iinjury Due to (or as a consequence of): ACUTE RENAL the Hospital or Attending Physician: The law requires that the death certificate be executed FAILURE that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 Yes 2 to 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2  $\boxtimes$  No 3  $\square$  Probably 4  $\square$  Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a Was an performe Yes 2 N 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this eral Director: After thi filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural (Month, Day, Year) injury 5 Pending 2 Accident
3 Suicide
4 Homicide M 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direc 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one) 29b. Signature and title



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 04, Gladys DeLasNieves Olivares Walborn 2010 3:05 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Gilchrist Hospice Center Towson . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birtholace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🏝 Hours Month, Day, August Til Til, Chile 215-98-5693 68 05, 1942 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "marshing injury or other trainmass." 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Baltimore County Timonium 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4 Daria Court 21093 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: Chilean Specify: Chilean 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **02** Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Aquilles Olivares Josefina Villaseca 19a. Informant's Name/Relationship (Type, Print) (Son/Only 🕩 🖟 ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Maryland 21093, U.S.A. Mr. Francis Augustus Walborn 4 Darcia Court 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Location - City or Town, State ( Harford County) Evers Fureral Chapel and 4 Donation 5 Other (Specify) Forest Hill.Maryland Cremation Services, Inc. 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center. P.A.
2325 York Road Timonium, Maryland 21093-2215, U.S.A. 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Jur h (Lic. #100677) Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ olon disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Example 3 Cause (Disease or iinjury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of). resulting in death) Last To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠y-9 ☐ Unknown 9 Unknown Part II. **Other** sig<mark>nificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagn 2 DM 2 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my actions, death assumptions. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

NN

s of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G908 10/01/10 JH State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9 48 PM LeRov Wilkinson, Sr. Theodore 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FRANKLIN SQUARE Hospital Rosedale 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1**x** M 2□ F Director 228-38-1367 08-04-1933 Virginia Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Evantime must be confilled at 1 ☐ Yes 2XXNo Director Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2807 Oak Grove Avenue 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♣ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 0 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2XXXNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Product Mechanic Manufacturing Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fand Mental 27 is marked traumatic e Norman M. Wilkinson Clara Gilmore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Georgie M. Wilkinson - wife 2807 Oak Grove Ave., Baltimore, Maryland 21227 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages . jo Important: If it any injury or c 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park 09-07-2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Lice MMP., Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiopulmonary arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last anding physician and use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 TVes 2 TNo been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐Yes 2 ☑No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ours after death.

neral Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Divatural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) RESODOO 2 - 2010 ss of person who completed cause of death (Item 23a) (Type, Print) FRANKLin Square DR Ballo Md 21237 JOH omana 9000 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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V

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HARD Day 2010 Physician/ Month 08 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OMBI COUNT HOWARD HOWAR1 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Numbe 6. Sex . Age (In vrs. last birthday 8. Date of Birth **Funeral** Hours 1 XX M 2 | F April 22, 1945 California Director 561-60-3877 65 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 🗌 Yes 2 🌁 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6248 Wild Swan Way 21045 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musone. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2XX Married Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bio-Technology Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Delmar Walters Mary Church 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 21045 6248 Wild Swan Way Elizabeth Jovce (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Atlantic Crematory 8-31-2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 2  $\square$  No the the funeral director, page 2 should be detached g 🗌 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital ᅆ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending after death. Director: Af 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENERALHOSPITA NT 31. Date filed . Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND LITEM#1perPHYS G907, 9/10/2010, WS
State of Maryland / Department of Health and Mental Hygiene

		-	For State of Maryland / Bep State Registrar Ce	ertificate of Death		No2010 27892
1	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Jean B. Wooten		2. Date of Death Month August	28 2010 3: Time of Death 7:40am M
-	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	I magase	4c. County of Death
	Funeral		Fairhaven  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)	Sykesville  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Carroll  9. Birthplace (State or Foreign
	Director		221-07-4670 1 M 2XF 96 Yrs.	Months Days Hours Min.	16787191	end Country) Texas
	land show	tor	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	he Man or 28a- e notifie	Director	Md Carroll Sykesvi	10f. Zip Code	10g	1 ☐ Yes 2 No  Citizen of What Country?
	h with the same of	Funeral	7200 Third Ave	21784		USA
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene.  The man Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Wildowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
15-(	72 hou In "nati Medica	mplei	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business Industry
212	iled within I Hygiene. other tha ent, the I	ادہ ا		School Music Teac		Education
land	l be filed fental Hy rked oth tic event	10 B	17. Father's Name (First, Middle, Last) Robert Young Barber		e (First, Middle, Maid g Leffland	
	d 2 should be fil alth and Mental 127 is marked or er traumatic ev			ling Address (Street and Number or Rura 203 Gittings Ave Ba		
Baltimore,	permit. Page 1 an Department of He Important: If Iten any injury or oth		The political of the control of the	ematory or other place) ity Cremation 08/31	./2010 Sy	c. Location - City or Town, State rkesville, Md.
Balt	permit. Depart Import any inj	ı, i	21. Signature of Fund Al Service Licensee	2. Name and Address of Facility Hai P.O. Box 195 Sykes	ght Funer sville,Md.	cal Home & Chapel P.A. 21784.
	nysician Medical Examiner	ıer	Due to (or as a consequence of):	ter the mode of dying, such as cardiac of	4	Approximate Interval Between Onset and Death
% 09 <i>L</i>	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  b. Due to or as a consequence of:  C. Due to (or as a consequence of):  d.			
P.O. Box 68760	he death certif y the attending ched for use a	Physician/Medical		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
s, P.O	iires that t signed b id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death?
ecord	The law requate has been page 2 shou	Completed			24a. Was an autopsy performed	
talF	ician: The law certificate has rector, page 2	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	k only one)	
l of V	ling Phys n. After this ( uneral dir	ate: To	1  Yes 2  No 1 Inpatient 2  ER/Outpatie  27. Manner of Death 1  Natural 5  Pending  (Month, Day, Year)  28a. Date of injury (Month, Day, Year) injury	ent 3 DOA 4 Nursing Hopf 28c. Injury at work?	ome 5 Residence 28d. Describe how i	e 6  Other (Specify) njury occurred
Division of Vital Records,	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   28e. Place of Injury - At home, farm, si building, etc. (Specify)		28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
_	e Hospite 24 hours e Funera leted fille	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or inversion only one)  2 Medical Examiner: On the basis of examination and/or inversion only one)  3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred a	t the time, date and p	lace, and due to the cause(s) and manner stated.
	To the within To the Comp	2	29b. Signature and title of cellifler	29c. License number	29d.	. Date signed (Month, Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, William Tan MD 1645 Like	Print) Rocal	Elders!	ougust 30 2010
	Star Registra		31. Date filed (Month, Day, Year) SFP 0 7 2010 32. Registrar's Synature	hed		

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G907, 9/17/2010, WS
State of Maryland / Department of Health and Mental Hygiene 20 | 0 27893 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4Month Physician/ 11.28 AM UGNIST Medical 4a. Facility Name (if not institution, give street and number, 4b. City, 4c. County of Death Examiner HOPKINS Barriew Medita 8. Date of Birt 01-08-1945 irthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** irtn<sub>i</sub>... Jountry) **MD** Months 218-42-4269 1 M 2 😾 F Hours (Month, Day, Year) 65 **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoiury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 😿 Yes 2 ☐ No **ESSEX** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 979 HONEYWOOD PLACE 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 X Never Married 2 Married 1 Yes If Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced Specify: BLACK Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) BENEFITS EARNING TECH SOCIAL SECURITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JAMES LEE WADDELL DORIS E. GRAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KELLEY WADDELL/DAUGHTER 1115 TACE DR. APT 3C. ESSEX, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 ☐ Other (Specify) STANISLAUS CEM 9-09-2010 BALTO. MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 a.m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Du to (or as a cons uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): nous or Attending Physician; The law requires that the death certificate be executed burial-transi signed by the attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Month Day Year be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case arred to medical Be 26. Place of Death (Check only one) examin ? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DCA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Multical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Cartifying Nurse Fractioner: To the best of my knowledge death or 29b. Signature and title of certifier 29c. License 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) av 04 31. Date filed Month, Day, Year) 32. Resistrar's Signature State Registrar

W DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27894 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST AKINSIKU 2010 KEHINDE 9:49 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S GREENBELT 7907 GREENBURY DRIVE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min (Month, Day 1 🗆 M 2 😾 F NIGERIA 57 Director 214-33-1215 1952 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No PRINCE GEORGE'S GREENBELT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7907 GREENBURY DRIVE 20770 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE REGISTERED NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ ADEYELE ADETUJOYE EYEOLA AKINNIBOSUN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7907 GREENBURY DRIVE GREENBELT, MARYLAND 20770 CLEMENT AKINSIKU/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MARMONY CEMETERY 8/21/2010 LANDOVER, MARYLAND 21 Signature of Funeral Service J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ BREAST CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Yes 2 No 1 Yes 2 L ed by the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 2 TNo Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tes 2 **X**No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 TResidence 6 Other (Specify) • 24 hours after death. • Funeral Director: After the leted filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate; (Month, Day, Year) 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 塩 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D23743 AUGUST 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Box 68760

P.O.

Records,

**Division of Vital** 

MARTIN WELTZ M.D.

7525 GREENWAY CENTER DRIVE #205 GREENBELT, MARYLAND 20770

10-05111 Richard Leon Belt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2010 27895

Richard Leon Belt			of Maryland /	Certif	ficate of i	Death	14 11/4/	, .	Reg. N	o.	
	В.	For State		COLUM	70010 07 7			2. Date p	f Death		3, Time of Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 08 Linda Lee Baldridge 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICONICO TENINSULA SALISBUR MEDICAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8 Date of Birth Funeral Hours (Month, Day, Year) 48 1 M 2 XF 62 Maryland Director 219-46-4447 Usual Residence of Decedent "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10b County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 522 Winder Street, Apt. death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the <u>Medical Examin</u> Completed by 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Line Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Edith Vananaza Charles Lee Shockley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 522 Winder Street, Apt. 51, Salisbury, MD 21801 Oliver John Baldridge/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Crematory Of Delmarva 8/23/2010 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Zeller Funeral Home, P. 0 1212 Old Ocean City Road, 0. Box 3171 d, Salisbury, MD 21802 Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Stzuno Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury -transit and that initiated events Due to (or as a consequence of) tending physician ar r use as the burial-tr resulting in death) Last Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No jo Month Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hinknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director, After this certificate has filled in by the funeral director, page 2.9 autonsv performed 1 ☐ Yes 2 ☐ No 2 KING Yes 25. Was case referred to medica To Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred

The law requires that the death certificate be executed P.O. Box 68760 Records, of Vital Hospital or Attending Physician: Division To the Hospital of within 24 hours a To the Funeral C completed filled

Maryland 21215-0036

Baltimore,

6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

(Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carroll St.

Medical

1 Thatural

Accident

5 Pending

Investigation

injury

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 27897 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2010 11:01a M August Chester H. Boltz /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 1, 9. Birthplace (State or Foreign Country) D A 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1XM 2□ F PA 80 Yrs. 165-24-0893 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director Ceci1 MD Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21904 USA 28 Orchard Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8 Manufacturing Foreman Machinist ages 1 and 2 should be filed vant of Heelth and Mental Hygie t: if item 27 is marked other it yo or other treumatic svent, II. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John A. Boltz Lydia D. Neidia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Heelth and Important: if item 27 is m any injury or other treum once. 28 Orchard Dr. Port Deposit, MD 21904 Reba Boltz / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8/23/2010 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Rising Sun, MD R.T. Foard Funeral Home, P.A. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. 111 S. Queen St. Risign Sun, MD 21911 ward 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one suise on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 8 Ce Physician 3V06B /Medical Due to (or as a consequence of): Examiner Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical signed by the ettending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions opntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one examiner? Hospital: Other: 4 🗋 Nursing Home 5 🗋 Residence 6 🗆 Other (Specify) 1 Ampatient 2 ER/Outpatient 3 DOA Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death 1 ☐ Yes 2 ☐ No Director: / ∠ ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funerei Direct completely filled in by 4 🗍 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print) 30. Name and address of person Ave Haure de Grace Mo 21078 IRINA MIKITYANSKAYA 501 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2010 Registrar

10-06233 Richard Bish

Amend Item 21 per fh,g907,09/23/2010dhb
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1	Co	ertificate of De	eath		Re	g. No. 2010	27898				
	/sicia	n/	Registrar  1. Decedent's Name (First, Middle,Last)				Date of Death     Month	n Dav Year	3. Time of Death				
dical E	kamir	ner	Richard Hayes Bish				August 18,	2010	1148 hrs				
			Facility Name (if not institution, give street and number)     103 Dutchess Road		nty, rown, or nestertow	r Location of Deat <b>/n</b>	n	4c. County of Dea Queen Anne					
Fun	oral	-			Under 1 Yea		s. 8. Date of Birt	h(MM/DD/YYYY) g. B					
Dire			194-24-8649 1XM 2_F 76		onths Day	s Hours Min	01/14/	1934 Fore	ign ountry) <b>PA</b>				
	'n	ļ	Usual Residence of Decedent  10a. State 10b. County 10c. Ci	ity, Town or Location					10d. Inside City Limits				
	ow any			hestertown					1 Yes 2 X No				
yland	a-f sh	흲	10e, Street and Number		. Zip Code		10	g. Citizen of What Co	untry?				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	s 23a or 28a-f show a e notified at once.	Director	103 Dutchess Road		2162	20		USA					
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ırs aftı	tural"	ā	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Us	sual Occupa	ition (Give kind of		16b. Kind of Business					
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215-0036 be filed within 7 ntal Hygiene.	it: If item 27 is marked other than "natural other traumatic event, the Medical Examin	Be Co	17. Father's Name (First, Middle, Last)  Ralph Eugene Bish				e (First, Middle, Mothy Wi						
212	mark c ever	리	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Add	ress (Stre			ber, City or Town, Sta	te, Zip Code)				
MD 12 sho th and	n 27 is umati		Curtis Bish - Son					ourg, PA 1					
re, s l and f Heal	If iten		1 X Burial 2 Cremation 3 Removal from State	<ul> <li>b. Place of Disposition crematory or other p</li> </ul>	lace)		Date	20c. Location - City of					
Baltimore, MD permit. Pages 1 and 2 sh Department of Health and	tant: or oth		4 Donation 5 Other Specify:	Crumpton Co		-	23/2010						
Balt permit Depart	Importing		21. Signature of Funeral Service Licensee  Jason Fellows per DVR					elfenbein n, MD 2162					
Physic	cian		23a. Part I. Enter the disease, or complications that caused the dea		_			_	Approximate Interval Between Onset and				
/Med Exam			failure. List only one cause on each line.  Immediate Cause (Final disease a. Contact gunshot would be caused in the contact gunshot would be caused in the cause of the caused in the c	nd of chest					Death				
Exam	IIIÇI		or condition resulting in death)  Due to (or as a consequence	∋ of):									
		ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence	e of):			-						
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
anted	nd ransit	Ë	dd.										
) oe exec	physician and the burial - transit	Medical	UNPENDED AMENDED										
760, ficate be	g phys		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pr		aath 3	Ectopic pregn	ancv	23d. Date of delive Month	ry Day Year				
Box 687 e death certifi	e attending p for use as th	Physician/	past 12 months?  4 Pregnant at time of	death	(Specify)								
<b>Bo</b> )	유	hys	1 Yes 2 No 9 Unknown g Unknown				Loo- Dida		the same of death?				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	signed by the detach	Ē	Part II. Other significant conditions contributing to death but no	t resulting in the under	lying cause	given in Part I.		bacco use contribute t	obably 4 🗹 Unknown				
<b>ds,</b> equire	should b	Completed					24a. Was a		autopsy findings available				
COF e law r	2 2	mp					autops perfor	med? death?	completion of cause of				
l Re	certificate ector, page	ပ္ပို	25. Was case referred to medical		26.Plac	e of Death (Check			2 110				
Vita ysicia	dr. Br	ĕ	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nursi	ing Home 5 1	Residence 6 🗸 Oth	er. Scene				
Division of Vital Records, lal or Attending Physician: The law requirers after death.	After	ī.	27. Manner of Death 28a. Date of Injury (Mogth, Day Year)	28b. Time of Injury 1119 hrs		ury at Work? Yes 2 ✔ No	28d. Describe h Subject shot	ow injury occurred					
Sior Attend	ector: by the	catio	2 Accident Investigation				28f. Location (S	treet and Number or F	Rural Route Number, City				
Divisior  To the Hospital or Attene within 24 hours after death	To the Funeral Director: completely filled in by the	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc.  3 V Suicide 6 Could not be determined (Specify) Home  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 103 Dutchess Road, Chestertown, M										
Hospi 24 hou	Funer stely fil		29a. Certifier 1 Certifying Physician: To the best of my knowl										
To the within	To the	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or investigation, i			at the time, date a						
		Σ	29b. Signature and title of certifier		29c, Licen		CME	29d. Date signed (M August 19, 201					
			Thudne M. King Jh.	14:D	0.0.	vi	ICME	, lugust 13, 201					
			30. Name and address of person who completed cause of death (It Theodore M. King, Jr., MD. Assistant Medica		l Penn St	treet, Baltimo	re, MD 21201						
	- 0	ate	31. Date filed (Month, Day, Year) 32. Registrar's Sign										

DHMH 17 Rev 1/2001

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		For State		State c	of Mary	land / De	partme <i>ertifica</i>			and N	flental Hy	gien	ie			
		Registrar  1. Decedent's Name (First, M.	iddle, Last	·)			erunca	le oi L	Jeani		2. Date of De	Reg. I	<del>20</del>	10	27899	
Physicia Medi		Katherine		ogan			Besse				August	- 1	oay 2010	Year )	6:30 A <sup>M</sup>	
Exami		4a. Facility Name (if not institu	_					y, Town, or		of Death		4	4c. County of Death			
<u> </u>		Golden Rule A  5. Social Security Number	ssist 6. Se			yrs. last birthda		ck Ha		r 24 Hrs.	8. Date of Bi		Kent	9. Birthplace (State or Foreign		
Funeral Director		218-16-6204		М 2 <b>X</b> Д F	86		Months		Hours	Min.	(Month, Da 09-20-		3	Count Mary	1and	
how at	٦	Usual Residence of Deceden 10a. State 10b. Co			10	c. City, Town or	Location							11	0d. Inside City Limits	
//arylar 8a-f s tiffied	Funeral Director	MD Kent			R	ock Hall	1								1 X Yes 2 □ No	
the Na or 2		10e. Street and Number			120	Jen Hai		ip Code				10g.	Citizen of W	hat Coun	try?	
th with ms 23 must	iner	20806 Bayside	Aver	_	=			.661			16 34 34	USA	1			
DEJILITIOTE, INIGITY ISING Z.I.Z.I.3-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ 3 陷 Widowed 4 ☐ Divo		12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	rces? 2 <b>X</b> No	in U,S.	If Yes, spe	edent of Hi ecify Cuba 2 <b>\_3</b> \no	n, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)		14. Race Black Specify:	, White, e	etc.	
2 hou "natu	Completed	15. Dec (Specify only)	cedent's Ed			i (Gi	cedent's Us ve kind of w	ork done a	ation during mo	st of work	ing	16b.	Kind of Bus	iness Inc	ustry	
vithin 7 iene.		Elementary/Seconday (0-	12)	College (1	-4 or 5+)	1	. <i>DO NOT u</i> egal S	,	tary			5	Secret	ary		
yiand a d be filed v Mental Hyg arked othe	) Be	17. Father's Name (First, Mid					U				e (First, Middle	, Maide	n Surname)			
Lyla	욘	Joseph Magrog		D: #		1				су Ма						
INICA 12 sho alth and 27 is i		19a. Informant's Name/Related Carolyn Vansa			er		•	•			i Route Numbe 11e,PA			ite, ∠ip C	ode)	
of Hee	1 8	20a. Method of Disposition 1   ↑ Burial 2   ☐ Crema			2	20b. Place of Dis		ame of	-		Date		Location - C	City or To	wn, State	
Dallillor  Dermit, Page 1  Department of mportant: If it is any injury or o		4 Donation 5 Ott	ner (Specify	)		Still Po	ond Ce	meter	ry		4/2010	St	:i11 P	ond,	MD	
Deparit Deparit Impor any in		21. Signature of Funeral Sen	rice License	elfe	bei	n l	22. Name a Fello 130 S	ws, H	lelfe	nbei	n & New	nam . M	Fune:	cal E	lome	
		23a. Part 1. Enter the diseas shock, or heart failure.				death. Do not e	enter the mo	de of dying	g, such as	s cardiac o	or respiratory a	rrest,			Approximate Interval Between	
Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)		a.	onic	inters	tid	lengi	desce	ie u	, Ha d	rox	'Le'	L	Onset and Death	
Examiner	I			Due to		esolra	tom (	aelur	& GY	100	nger				·	
p it	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	2	Due to	(or as a co	nsequence of):	)				, ,					
r ou cate be executed physician and the burial-transit		Cause (Disease or iinjury that initiated events resulting in death) Last	1	c. Due to	(or as a co	nsequence of):										
ot te be e hysiciar he buris	edical		L	d												
ertificat ertigation ding ph		IF FEMALE:													-	
box e death c the atten hed for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown			Birth 2 [	Fetal death	3		у				23d. Date Mon		ery Day Year	
US, F.O.	by	Part II. Other significant con								t I.					e cause of death?	
Records, The law requires ate has been sig	Completed										24a. Was auto perf 1 \(\sum \) Yes	psy	pr	ere autopior to coreath?	osy findings available mpletion of cause of 2  No	
VICAL lysician: is certific director,	Be	25. Was case referred to med examiner?	100	Hospital: _				Othe	or.		( only one)				Assisted	
9 Physer this eral di	e: 70	27. Manne Death	Taker.	28a. Date	of injury	2 ER/Outpa 28b. Time	of	28c. Injury	4 <u></u> N ⁄at		me 5 Resi 28d, Describe				Living	
eath. or: Aft	Certificate		ending vestigation ould not be		th, Day, Ye	<i>ar)</i> injur	M	work 1 🗆	Yes 2	□No						
DIVISION OF all or Attending P s after death. Il Director: After the ed in by the funera	Cert		etermined	28e. Place	of Injury - ng, etc. (S)	At home, farm, pecify)	street, facto	ry, office			28f. Location ( City or To			or Rural	Route Number,	
L Hospita ne Hospita in 24 hours ne Funeral pleted filled	Medical	(Check 2 \( \subseteq Medi	cal Examir	ner: On the bas	sis of exam	knowledge, dea ination and/or in of my knowledg	/estigation, i	n my opinic	on, death o	occurred at	the time, date	and pla	ce, and due t	to the cau	ise(s) and manner stated.	
		29b. Signature and title of se		· Ros	> In G	)	29	oc. License		31.		29d. [	Date signed	Month, E	ay, Year)	
15		30. Name and address of per	rson who co	ompleted caus	se of death	(Item 23a) (Type		^			14 4					
Rm Sta	lo-	Susin K. Ros 31. Date filed (Month, Day, Ye	5, m.D	5/6	(egistrar's	sing for signature	Hre.	Clo.	state	NA	Md.	216	20			
Registi		AU	G 1 7	2010	Denn	m B.	po	Jes J								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar #11 & 19a, 8/18/10 M.S.Kent Certificate of Death Amended Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bowden racy 2010 Medical 4a. Facility Name (if no institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Say Anchoras Wicomico 5. Social Security Number 6.Gex . Age (In yrs. last birthday) If Under 1 Year If Under-24 Hrs. 8. Date of Birth Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Day, Year West Virginia Director 236.48.8686 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Millington Oueen Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral USA 21651 209 Lime Landing Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic auant than "natural", or in the injury or other traumatic auant than "natural", or in the injury or other traumatic auant than "natural", or in the injury or other traumatic auant than a second than the injury or other traumatic auant than a second than the injury or other traumatic auant than the injury of the injury or other traumatic auant than the injury or other traumatic auant than the injury or other traumatic auant than the injury of the injury or other traumatic auant than the injury of the injury of the injury or other traumatic auant than the injury or other traumatic auant than the injury or other traumatic auant than the injury of the injury or other traumatic auant than the injury of the injury or other traumatic auant than the injury of the injury or other traumatic auant than the injury of the injury or other traumatic auant than the injury or other traumatic auant the injury or other δ 1 Never Married 2 X Married 1 X Yes If Yes, Give Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ X o Specify: 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Plumbing Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Macy Fowley Mark Bowden 19a. Informant's Name/Relationship (Type, Print)
Granddaughter
Comic Ann Hults - Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hurlock, MD 21643 P.O. Box 1197 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/16/2010 Crumpton, MD Crumpton Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityFellows, Helfenbein & Newnam Kick Speer Road Chestertown, MD 21620 30 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final ESR D Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): ∠xaminer Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires the death certificate be executed within 24 hours after death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown ☐ Yes ∠ ☐ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 M Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: Matural injury 5 Pending 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Salisbing, 170 21804

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryl	and / Depa <i>Cer</i>	artment of H tificate of D	lealth and N Death		ene 201	0 27901
Physici	an/	1. Decedent's Name (First, Middle, La.	st)				2. Date of Death Month	Day Year	3. Time of Death
Med	ical	Delores  4a. Facility Name (if not institution, give	Ann		Baker	Laurian of Dark		9 2010	7:58 A M
Exami	ner	7474 Esham Road	street and number)		Parsor	Location of Death		4c. County of De Wicomi	
Funera		5. Social Security Number 6. S	ex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. B	irthplace (State or Foreign country)
Directo		Usual Residence of Decedent	64	Yrs.			4-9-1946	Ma	ryland
land show dat	Į.	10a. State 10b. County	10c.	. City, Town or Lo	cation				10d. Inside City Limits
Mary 28a-f ootifie	Director	MD Wicomi	co	Parsonsb					1 🗆 Yes 2 🔀 No
ith the 23a or st be r	ral	10e. Street and Number			10f. Zip Code 2184	<b>΄</b> Ω	100	g. Citizen of What ( USA	Country?
eath w tems	Funeral	7474 Esham Road 11. Marital Status	12. Was Decedent Ever in		Vas Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	14. Race - An	
land 27215-0036  be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at.	b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Yes 2 X No	n, Mexican, Puerto Specify:	Hican, etc.)	Black, Wh	ite, etc. Vhite
15-(	Completed	15. Decedent's E (Specify only highest gr		(Give I		ation Juring most of worki	ing 16	6b. Kind of Busines	s Industry
within giene.		Elementary/Seconday (0-12)	College (1-4 or 5+)	- 1	O NOT use retired) Homemaker			Own Hor	ne
filed v filed v fa othe	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Mai	den Surname)	
Maryland 2 should be filed th and Mental Hy 27 is marked oth traumatic event		William (Date of the Control of the	Constant Control	Truitt Mary			Elle		Baker
Ma 12 sho 11th and 27 is 1		19a. Informant's Name/Relationship (1)  Vickie L. Sellers			-		al Route Number, Ci pad, Pitt	-	21000
of Hee		20a. Method of Disposition	20	b. Place of Dispo				lc. Location - City	
<b>Baltimore,</b> Dermit. Page 1 and Department of Hee Important: If item any injury or othe pnee.		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	fy) I	Pittsvil	le Cemete	ry 8-21	L-2010 P	ittsville	e, Maryland
Baltimore, Maryland permit. Page 1 and 2 should be filed. Department of Health and Mental H Important: if item 27 is marked of any injury or other traumatic even once.		21. Signature of Far eral Service Licen	ellis tachi	70	. Name and Addres	n Street	ounds Fun Salisbu	ry, Mary	e Land 21804
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the d ne cause on each line.	leath. Do not ente	r the mode of dying	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between
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- ±	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):					
f <b>6U</b> sate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):					
C be ex sician	edical I		l d.						
<b>68 / 60</b> sertificate b ding physicse as the b	Med	IF FEMALE:							
<b>BOX</b> death catter he atterned for u	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Date of o	elivery Day Year
that the	by Ph	Part II. Other significant conditions of	ontributing to death but not	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
dS, quires en sign							1 XVes	2 🗆 No 3 🗀	Probably 4 🗆 Unknown
VITAI KECOYDS, vysician: The law requires is certificate has been sig director, page 2 should b	Completed						24a. Was an autopsy performe	prior to d? death?	utopsy findings available completion of cause of
cian: certifica	Be	25. Was case referred to medical examiner?	Hospital:		_	ace of Death (Check		42.1	
Physi Physi rthis o	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2  28a. Date of injury	ER/Outpatien 28b. Time of	t 3 DOA Othe	4 □ Nursing Ho	me 5 Residence 28d. Describe how		ecify)
on C nding ath. r: After	ertificate:	1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Year	r) injury	work'	? Yes 2 □ No	200. Describe now	injury occurred	
DIVISION OT tal or Attending PI rs after death. al Director: After th ed in by the funeral	ျပ	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (Stree Gity or Town, S		ural Route Number,
Hospite 24 hours Funera leted fille	Medical	(Check 2 Medical Exam	sician: To the best of my kn iner: On the basis of examina se Practioner: To the best of	ation and/or invest	igation, in my opinio	n, death occurred at	the time, date and p	place, and due to the	e cause(s) and manner stated.
To the within To the comp	2	29b. Signature and title of certifier	12	,iomougo, c	29c. License	number	29d	. Date signed (Mor	th, Day, Year)
60		) The	/_		03	30690		Aug. 19	2010
- Cast	,	30. Name and address of person who	completed cause of death (I	Item 23a) (Type, P	rint)	co/1 5T.	501.	56 Ur =	th, Day, Year)  20 / S  MD
	ate	31. Date filed (Month, Day, Year)	33 Registrar's Sig	gnatue do	W.		,	7)	•
Regist	rar	700 20 20		~ 7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0331 Robert Kent Carroll Sr. 08 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Union Hospital of Cecil County E1kton If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 7. Age (In vrs. last birthday) 1 💢 M 2 🗆 F Days Hours Min. (Month, Day, Year, 04/19/194 Country) Maryland 69 Director 215-38-1573 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo MD Ceci1 Earleville 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 21919 USA 4975 Augustine Herman Highway 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ۵ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 X Divorced White Year or Dates permit. Page 1 and 2 should be filled within 72 hour Department of Health and Nental Hygelne. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Health Caretaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Carroll Lillian Darroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Brandywine Road Bear, DE 19701 Tammy Brakefield - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Stevensville, MD 08/30 Chesapeake Cremation Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam uk A. 130 Speer Road Chestertown, Maryland 21620 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Rectal Cancer Physician/ .ung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami that the death certificate be executed Due to (or as a consequence of) nding physician use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, t 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c} \begin{array}{c} \beg 1 Yes 2**X** No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier DO054086

Registrar
DHMH 17 Rev 7/2009

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State

High Street, Suite 104 Elkton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Khatri

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Physician/ Month CREIGHTON 02 05 AUGUST 2010 TANE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORB UNIVERSITY OF MARYLAND MEDICAL BALTIMORE CITY CENTER 9. Birthplace (State or Foreign Country)
PA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □X= Months 09/05/1951 **Director** 172-42-2256 58 Usual Residence of Decedent "naturat", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Rock Hall Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20775 Mercer Avenue 21661 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Woodward Evelyn Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20775 Mercer Ave. Rock Hall, MD 21661 Jodi Lee Creighton - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 8/23/2010 Chester, Maryland 4 Donation 5 Other (Specify) Chesapeake Cremation Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam up of 130 Speer Road Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ACUTE KESPIRATORY disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ACUT ANCREATITI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Other (specify) Day Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ABUS & ALCOHOL 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has I performed 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Tes 1 Nanatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes Accident
Suicide within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 2 29d. Date signed (Month, Day, Year) AUGUST 21, 2010 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANJUNAM BALTIMORE, MD 21201 MARKANDAYA S. GREENE ST.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23 Day 2010 2:40 A M Daniel Floyd Dixon, Sr. August Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 **X** M 2 □ F Months Days Hours (Month, Day, ) **March 6** 214-48-5549 65 °1945 **Director** Maryland Usual Residence of Decedent show 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27040 20659 Dixon Lane USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natu any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Manager Tire 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Leonard Thomas Dixon Carolyn Phyllis Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Floyd Dixon, Jr. / Son 28730 Hancock Drive, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Charles MemorialGardens 2010 28, Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Si na ure of Funeral Service Lice e Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Du to (or as a consequence of) Examiner eumonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury una that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year <u>р</u>О. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ enkopenia Dε κισ Division of Vital Records, 1 Ses 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Tes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 2 No 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bharathi Gowda, M.D.

31. Date filed (Mon

AUG 26 2010

25230

1410 Crain Highway, NW Ste. 4A, Glen Burnie, MD

21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend 19b per FD, State of Maryland / Department of Health and Mental Hygiene Registrar DOR, 8/25/10-LDB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8/20/2010 7:30A MICHAEL DITULLO Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESAPEAKE WOODS CENTER **DORCHESTER CAMBRIDGE** 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month Pay Year) Months Days Hours 1**X** M 2 □ F PENNSYLVANIA Director 406-14-5230 Usual Residence of Decedent or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 Yes 2X No MARYLAND DORCHESTER EAST NEW MARKET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21613 USA 5935 HERITAGE RD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 1 ☐ Yes 2X No Specify: | Hygiene. other than "natural", 3X Widowed 4 □ Divorced WHITE Year or Dates. 1948 traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Merical injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) CONTRACTOR PLUMBING/HVAC 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a CRONNER TO Route Number, City or Town, State, Zip Code) 30540 CROMWELL WAY, TRAPPE, MD 21673 BARBARA ALLEN / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ★ Burial 2 Cremation 3 Removal from State 8/23/2010 CAMBRIDGE, MD DORCHESTER MEMORIAL PARK 4 Donation 5 Other (Specify) Signature of Funeral Service Lice 22, Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST. CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Cardiomyopatt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin sician and burial-transit arteru that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last coronary Due to (or as a consequence of) Physician/Medical nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No ঠ Month Day Year signed by the a 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📜 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun M Natural 5 Pending injury 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

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Division of Vital

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-06410 State of Maryland / Department of Health and Mental Hygiene Charles Anthony Dryman Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 24, 2010 1456 hrs Dryman Medical Examiner Charles Anthony 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Calvert Lusby 12953 Mohawk Drive If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or Foreign-Washington 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 04/01/1975 Country) D.C. 35 Director 217-11-7096 1 X M 2 F Yrs Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 1 Yes 2 X No Lusby Calvert Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20657 12953 Mohawk Drive 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12 Was Decedent Ever in U.S. White, etc. Armed Forces? 1 Never Married 2 Married 1X Yes White Specify: 1 Yes 2 X No specify: If Yes, Give Year 1991-1994 4 X Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Automobiles 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daniel Wayne Dryman Sharon Lee Bayles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ဥ 12419 Coppermine Road, Union Bridge, Md. 21797 Ruth B. Younkins / Aunt 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan Crem. 8/30/10 Alexandria, Virginia 4 Donation 5 Other Specify 22. Name and Address of Eacility.
Muriel H. Barber Funeral Home Signature of Funeral Sovice Mienses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 20882 Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medinal Death Diabetic Ketoacidosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical AMENDED 23a,pt.II,27 per me g907 9-10-10 vt attending physician of or use as the burial -X UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown þ Hypertension Completed 24b. Were autopsy findings available 24a. Was an After this certificate has been funeral director, page 2 should prior to completion of cause of autopsy performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) fo the Hospital or Attending Physician: 25. Was case referred to medical 8 Other Nursing Home 5 Residence 6 🗸 Other Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 25, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Moliti), Day, Year) State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Reg. No Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Mamie Justine Domras 9, August 2010 4:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Burnett-Calvert Hospice House Prince Frederick Calvert Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2**X** F Days (Month, Day, Year) 09/17/1927 Months Hours Min. Director 234-42-5830 82 West Virginia Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Calvert Lusby 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20657 United States 181 Leason Cove Drive filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes Give 1 Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Assistant U. S. Government of Health and Mental Hygier of item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked or any injury or other traumatic ever Jessie H. Tuttle Tressie E. Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Philip C. Domras (Husband) 181 Leason Cove Drive, Lusby, Maryland 20657 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery | 8/30/2010 Cheltenham, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Rausch Funeral Home, P.A. 22. Name and Address of Facility 加 P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition resulting in death) ) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year 4 Pregnant at time of death 9 Unknown Month Dav signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š MESENTERIC ISCHEMIA, RENALFAILURE 1 Tes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed. Yes 2 No this certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Souther (Specify) HOSPICE 1 Yes 2 3 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 1 Natural
2 Accident
3 Suicide 5 Pending work Division 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

5

Medical

29a. Certifier (Check

State Registrar

31. Date filed (Month, Day, Year) AUG 2 0 2010

29b. Signature and title of certifier

Scaria Mathew, MD 11910 H. G. Trueman Road, Lusby, Maryland 20657 32. Registrar's Signature backs

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D 36969

29d. Date signed (Month, Day, Year) August 19, 2010

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

		Please	e Type or Prin					-		gible.		
		For State	State of Ma	arylan		partment of F ertificate of		Mental Hy	0.4	210	0 *	7000
		State     Registrar  1. Decedent's Name (First, Middle, Legistranse)	_ast)			er lincale of	Dealli	2. Date of De	Reg. No.		3. Tim	e of Death
Physicia /Medic		Frances	Violena		Dic	kerson		Augus	Day	Year 2010	12	• 30a
Examin		4a. Fecility Name (If not institution, g					or Location of Deat	h	4c. Cou	nty of Deatl	1	: 3 V a
Funeral			rson Road	e (In yrs. i	ast birthda	Abel y) If Under 1 Year	If Under 24 Hrs		st.	Mar 9. Birth	iplace (Sta	ate or Foreign
Director		214 30 0366	1□M 2□F	79	Yrs.	Months Days	Hours Min.		<sub>ay, Year)</sub> 5 <b>,</b> 1931		<sub>uintry)</sub> ` vlan	d
land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or I	Location		3 2				e City Limits
Mary a-f sho	ctor	MD St.	Mary's	A	bell						1 🗔	Yes 2 □ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Integration 1 the maryland Horizone. In marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street end Number 38705 Dicker	son Rd			10f. Zip Code	20606		10g. Citizen	of What Co	untry?	
ms 23	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.	S. 13	13. Was Decedent of Hispanic Origin? (Specify Yes or No-					rican India	1,
after or ite		1 Never Married 2 Married	If Yes, Give	No		1 ☐ Yes 2 ☑ No		to Hican, etc.)	Spe	lack, White	e, etc. Blac	k
hours tural"	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates: Education		16a. Dec	edent's Usual Occup	pation		16b. Kind of	Business/I	ndustry	
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lled will hygien her th nt, the		17. Father's Name (First, Middle, La	o#1		Со	ok	18 Mother's Na	me (First, Middle	1	ernm	ent	
id be fi ental H ked ot c ever	To Be (	William Whee						e Anna		,		
shou and M s mar	_	19a. Informant's Name/Relationship				iling Address (Street		ural Route Numi	ber, City or To	vn, State, Z	ip Code)	
l and lealth mm 27 her tra		Alfreda A. E.	step/daug		1	60 Finch	ct. I	Mechani Date				
ages I		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3		C	emetery, ci	rematory or other pla Heart C	ce) Cem 8-2	25-10	20c. Location Bush			3
mit. P partme sortan / Injun		4 □ Donation 5 □ Other (Special Service Lice)				22. Name and Addre		RISCOE			•	HOME
permi Depa Impo any Ir		Exembelly (	Buco-1	Onl		2294 Old	l Washir	ngton F	Rd Wal			
		23a. Part1. Enter the disease, or co shock, or heart failure. List on						c or respiratory	arrest,			mate Between and Death
Physician // // // // // // // // // // // // //		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ENA a consequ		FAILUR	£				2	MONTHS
Examiner		Sequentially list conditions	ь	1 164	TES						10	YHARS
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):							
be executed cian and ourial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):						_	
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certifica ding pl	Physician/Medica	IF FEMALE:	23c. If yes, outcome	nf nregna	incv	· ·-		· · · · · ·	004	D-44 4-1		
death cerl e attendin d for use	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	I death 3	B⊟Ectopic pregnanc	y			Date of deli Month	Day	Year
at the de by the a	hys	9 □ Unknown	9□ Unknown					1				
Attending Physician: The law requires that the death certificate refers. After this certificate has been signed by the attending physiby the funeral director, page 2 should be detached for use as the law that the funeral director, page 2 should be detached for use as the law that the funeral director, page 2 should be detached for use as the law that the funeral director.	by	Part II. Other significant conditions	contributing to death bi	ut not resi	ulting in the	underlying cause giv	ven in Part I.	1	tobacco use c Yes 2 <b>X</b> No			
aw requir s been si 2 should	Completed							24a. Was		b. Were au	topsy findi	ngs available
The lav	Com							auto perl 1∐ Yes	opsy formed? 2 X No	death?	1 .	of cause of
hysician: Th his certificate I director, pag	Be	25. Was case referred to medical examiner?	Hospital:			_ lott	ner:	ath (Check only				
g Phys er this eral dii	1: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Inju	ry	28b. Time	of 28c. Inju	4 LI Nursing	Home 5 Ares 28d. Describe	how injury oc		cify)	
ending F sath. or: After he funer	atio	1 Natural 5 Pending 2 Accident investigat		y rear)	Injury		Yes 2 No					
To the Hospital or Attendin within 24 hours after death.  To the Euneral Director: Accompletely filled in by the fur	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At ho c. (Specif	ome, farm, s	street, factory, office			(Street and Nu own, State)	mber or Ru	ıral Route	Vumber,
ospital hours a meral y filled		29a. Certifier 1 CertifyIng	Physician: To the best	of my kno	wledge, de	ath occurred at the ti	ime, date and plac	e, and due to the	e cause(s) and	manner as	stated.	
the Ho nin 24 I the Fu npletel	Medical	one)	aminer: On the basis of and manner sta	f examina ated.	tion and/or			curred at the time				
To vitt	2	29b. Signature and title of certifier	Bour,	11 O	)	29c. Licens			29d. Date sig			ır)
		30. Name and address of person wh	io completed cause of d	eath (Item	1 23a) (Typ	e, Print)	014161				A	
RRA		30. Name and address of person with Robert J. Baue 31. Date filed (Month, Day, Year)  AUG 24	r, M.D. 0	78103	The	ree Notch K	2d. #101,	Mecha	enicsv	1101	Ind.	20659
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month & 3. Time of Death Physician/ 1320 Zube Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Annapalis Anne Arundel Arundel Medical Anne 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral . Age (In yrs. last birthday) 8. Date of Birth 1 🗆 M 2 🗹 F Days Hours (Month, Day, Yea Country) Director 054 30 3718 Usual Residence of Decedent , or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 No Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informanț's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumonia disease or condition /weet Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on: or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 2 X No Yes Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be ☐ Suicide ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital ledical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29c. License number 2010 2404 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tm

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ Arthur Marion Dickerson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Miconico Medica ealonal 9. Birthplace (State or Foreign Country) VA If Under 24 Hrs 8. Date of Birth **Funeral** Months Days (Month, Day, Year) -10-1932 Director 78 31-36-963 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2 TyNo VA Accomac Parksley 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō "natural", or items 23a Funeral 263463 McThompson Rd 23421 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Speci Black Completed 3 Widowed 4 Divorced the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Pocomoke Elementary/Seconday (0-12) College (1-4 or 5+) Monument Co. Truck Driver other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Lillian M. Cropper Gardner L. Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosie L. Dickerson/Wife 263463 McThompson Rd, Parksley, VA 23421 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Jerusalem Bapt Cem8-21-2010|Temperanceville, VA of Fun all Surviv 917 W. Isabella St. Salisbury, MD 21801 22. Name and Address of Facility Bennie Smith 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician CARPIOGEN Medical resulting in death) Due to (or as a consequence of): **Examiner** MADUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for us 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown ed by the a Unknown Records, P.O. s been signed by should be detail Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performe After this certificate If funeral director, page Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation Accident within 24 hours after death

To the Funeral Director: 

Sompleted filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

State Registrar 100

Carroll St. Salisbury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chodnic

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 JAMES EARNEST DAVIS 900 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country) 226-30-2955 Director 06/01/28 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🎘 No VA ACCOMACK ATLANTIC 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 10403 Atlantic 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ş 1 Never Married 2 Married 2 X No Yes timore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Madre (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 CONSTRUCTION ABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EDWARD DAVIS <u>VIOLA WISE</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> GRACE WHARTON - FRIEND</u> <u>1006 Haves Ave</u> <u>Salisburv.</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 4 Donation 5 D Other (Specify) Davis Family Cem. 108/21/10 <u>Atlantic.</u> 22. Name and Address of Facility <u> Cooper & Humbles Funeral Co.</u> Accomac cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Part 1. Enter the disease, or comp shock, or heart failure. List only o Onset and Death Immediate Cause (Final Physicians disease or condition resulting in death) Medical as a consequence of) Examiner Facunctially list conducting if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit ronic and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Month Day Year Pregnant at time of death 2 No has been signed by the 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thiknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed death? certificate | 2 No Yes 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2. No ၉ 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending after death. I Director: Al 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b./Sign 29d. Date signed (Month. Day, Year, amel and address of person who completed cause of death (Item 23a) (Type, Print) mueller 100 31. Date filed (Mont

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 17, 2010 Month Physician/ 7:30 P Auq. Barbara F. Ecker Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carroll Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days April 14,1957 1 M 2 X Months 53 Director 216**-**70-0725 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 XNo Westminster MD Carrol] 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21158 2906 Murkle Road death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Carroll Co. Schools Custodian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret L. Weidner G. Francis Kauffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 2906 Murkle Road, Westminster, MD Robert Ecker - husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or conce. 8/23/10 Marston, MD James Cemetery 22. Name and Address of Facili Pritts Funeral Home & Chapel, PA 21 Signat ve of Funeral Service Lid 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications the each. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eto fta Prusician/ disease or condition \* Medical resulting in death) Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Month Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2 ☐ No Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s perform 1 Yes 2 🗌 No this certificate **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ER/Outpatient 3 DOA ပ Inpatient 2 🗆 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Montin, Day, Year)

State Registrar 30. Name and

AUG 20

NJL

102

dress of person who completed cause of death (Item 23a) (Type, Print)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 00:08 AM August Bobby Joe Farmer Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Union Hospital of Cecil County E1kton Cecil 8. Date of Birth (Month, Day, Oct. 12 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Hours 1 🛛 M 2 🗆 F North Carolina ,1958 Director 184-52-5057 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland North East Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21901 United States 3385 Blue Ball Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Automobile Assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Betty A. Wilson David R.C. Farmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3385 Blue Ball Road, North East, Maryland 21901 Belinda Farmer / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Auguste 24, 1 ∑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oxford Cemetery 2010 Oxford, Pennsylvania 4 Donation 5 Other (Specify) 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition CEREBRAL INFARCT Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner ANOXIC Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine VENTRICULAR Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) 4 Pregnant a Pregnant at time of death signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No After this certificate has funeral director, 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation completed filled in by the 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D 63486 AUGUST, 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, ELKTON, MI) 21921 106 BON HAMANEH

State

Registrar

31. Date filed (Month, Day, Year)

AUG 23 2010

32. Registrar's Signature

10-06151 Davin Ferguson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

avin Ferguson	State 1- For State Registrar	of Maryland / Departme	ent of Health and Mental ete of Death	Hygiene Reg. No	2010 27914						
Physician Medical Examine	Decedent's Name (First, Middle,Last	FERGUSON		2. Date of Death Month Day August 17, 20	3. Time of Death						
	4a. Facility Name (if not institution, given Holy Cross Hospital	e street and number)	4b. City, Town, or Location of Di Silver Spring		4c. County of Death Montgomery						
Funeral Director	5. Social Security Number 6. Se 0 9 7 - 7 4 - 8 2 3 9 1 🗵	ex 7. Age (In yrs. last birth		Hrs. 8. Date of Birth (Min. May 24, 1	M/DD/YYYY) 9. Birthplace (State or Foreign New York Country)						
the Maryland tor 28a-f show any lifted at once.	Usual Residence of Decedent   10a. State   10b. County     Montgome     10e. Street and Number	ry Silver		10g. C	10d. Inside City Limits 1 X Yes 2 No itizen of What Country?						
2 hours after death with the 1 "natural", or items 23a or IEanniner must be notifie	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates:  Ny highest grade completed) 16a. D	20901  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 Yes 2 No specify: ecedent's Usual Occupation (Give kind uring most of working life. DO NOT use	of work done retired)	USA  14. Race - American Indian, Black, White, etc.  Specify: Black  Kind of Business/Industry  Private						
D 21215-0036 should be filed within 7 and Mental Hygiene. is marked other than afte event, the Medical TO BO Comple	Andrew Ferguson,	Jr.		ame (First, Middle, Maide tte Buchana	n Surname)						
Baltimore, MD 21 permit. Pages 1 and 2 should Department of Health and Mc Important: If item 27 is ma injury or other traumatite	Claudette Ferguso  20a. Method of Disposition  1 🗵 Burial 2 Cremation 3  4 Donation 5 Other Specify	1 X Burial 2 Cremation 3 Removal from State crematory or other place)									
Physician Ji al Examiner	failure. List only one cause on ea Immediate Cause (Final disease or condition resulting in death)  Seguentially list conditions.	Due to (or as a consequence of):									
68760, certificate be execunding physician and use as the burial - tra	UNPENDED	AMENDED  23c. If yes, outcome of pregnancy  1 Live birth 2  4 Pregnant at time of death 5  9 Unknown	Fetal death 3 Ectopic pre Other (Specify)		3d. Date of delivery Month Day Year						
tal Records, P.C. rian: The law requires that certificate has been signed I ector, page 2 should be deal	25 Was case referred to medical examiner?	contributing to death but not resulting	26.Place of Death (Che	1 Yes 2  24a. Was an autopsy performed? 1 Yes 2							
Division of Vii ital or Attending Physic ital or Attending Physic ral Director: After this lled in by the funeral director:	1 Yes 2 No	28a. Date of Injury POUND: Day, Year) On Aug 17, 2010 28e. Place of Injury - At home fan	me of Injury 28c. Injury at Work?  ID: 1 Yes 2 ✓ No	28d. Describe how in Subject hanged	jury occurred						
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	29a Certifier	ian: To the best of my knowledge, death	h occurred at the time, date and place,	10102 Renfrew Ro and due to the cause(s) a							
To or or	Men Branel	and manner stated.	29c. License number O.C.M.E.		Date signed (Month, Day, Year) gust 18, 2010						
2 5		ssistant Medical Examiner	111 Penn Street, Baltimore, M	1D 21201							
Stat Registra	VAIL CE SE SESTE	32. Registrar's Signature	Ked								

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2ay 24 2010 6:30 a M August Cynthia Marie Grove Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's Mechanicsville 37713 Brown's Way 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 047077 1955 1 M 2XXF Washington, DC Director 217-70-5797 55 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he natification. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No St. Mary's Mechanicsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37713 Brown's Way 20659 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2X Married Yes 2 K No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Helen Jameson James Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37713 Brown's Way, Mechanicsville, MD 20659 Thomas B. Grove/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 K Cremation 3 Removal from State Charlotte Hall, MD Brinsfield-Echols 08/26/2010 4 Donation 5 Other (Specify) 21. Sistemane of Internal Service Literates 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, MD 20622 Edward N. Brinsfield M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year the 9 Unknown ed by t signed t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 K Yes 2 No 3 Probably 4 Unknown been signatures Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has t page 2 s autopsy certificate | 1 ☐ Yes 2 ☐ No 2 X No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🕅 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accider☐ Suicide Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical

3 Rme

State Registrar

29a. Certifier

(Check

only one)

3

29b. Signature and title of certifier

Jennifer Schmidt, D.O.31. Date filed (Month, Day, Year) AUG 26 2010

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

40900 Merchants Lane, Leonardtown, MD 20650 Registrar's Signatu

1 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0055751

29d. Date signed (Month, Day, Year)

08/25/2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 20, 7:55a<sup>M</sup> 2010 August Beulah Marguerite Gibson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 607 North Main Street Dorchester Hurlock If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 15,1923 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🛛 F Maryland 87 Director 220-16-8127 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Dorchester <u>Hurlock</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code USA 607 N. Main Street 21643 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Hospital Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental P Wesley Franklin Bowie Clara Alberta Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a lant: If item 27 is jury or other trains Gloria Gayle Bowie/Niece 607 N. Main Street, Hurlock, Maryland 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 Removal from State Department o Important: If any injury or 4 ☐ Donation ☐ Other (Specify) Unity Washington Cem. 8/23/2010 Hurlock, Maryland 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, MD 21631 21. Signalure of Fur eral Service Lice eart1 Enter the disease, or complications to shook, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 2010 **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tran Due to (or as a consequence of): physician Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has te 2 autopsy page performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 2 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLLING MIC/1401 302 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

death with the Maryland

72 hours after

1 and 2 should be filed within

requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Hebb Peter Χ. 2010 4:03 August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** (Month, Day, Year) 01/16/1956 Hours 1 XM 2 | F Director 577-84-8837 54 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No St. Mary's Lexington Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20653 19326 Pulliam Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black White etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 X Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 Yes 2XXNo Specify: 3 Divorced 4 Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Contractor Construction Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Louise Barber Charles Hebb Florence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 285, Loveville, MD 20656 Margaret A. Holt/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State Charles Memorial Cem | 08/24/2010 | 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, MD 21. Sig sture of F neral Service iccuses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 Brinsfield, Jr. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Ph\_sician/ ARDIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** YEARS ABETES Sequentially list conditions, if any parting to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably icale has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient

the Hospital or Attending Physician: The law requires that the death certificate be executed of Vital Division

within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, to

Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nuise Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20650 UROGBEMI LEON ARDTOWN MD

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number,

State Registrar 27. Manner of Deth

Matural

Accident Suicide

☐ Homicide

5 Pending

Investigation

determined

6 Could not be

28a. Date of injury

(Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Lillian Luve11 Hubbard a M 2010 8:45 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester Cambridge Chesapeake Woods Center If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month Day, Aug. 17, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 V F Year 940 215-36-1510 Maryland Director 70 Aug. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b Counts 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Dorchester Secretary 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3751 Sunnyside Road 21664 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Saltimore, Maryland 21215-0036 filed within 72 hours after white 1 Yes 2 No Specify. "natural", Specify: 3 Widowed 4 Divorced Completed and Mental Hygiene.
Is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) quality control oxygen tank mfg. other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 Is marked of any injury or other traumatic eve Charles A. Lane Dorothy Wheatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Stephens daughter 10169 Locust St., Laurel, DE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Dorchester Mem. Park 8/20/10 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Cambridge.  $_{\rm MD}$ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Interval Between Set and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate behin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis mpleted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Day Unknown 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 7410 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ᅆ 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 20 person who comp eted cause of death (Item 23a) (Type, Print) 30. Name and address of ARR ·O.

State Registrar AUG 23 2010

Registrar's Signature

10-06157

Jimmy D. Holi	n	State of Maryland / Department of Health and Mental Hygiene 2010 2791										
Physic	sian/	Registrar  1. Decedent's Name (First, Middle, Last)	ficate of Death	Reg. No.	0.							
Medical Exar			n Hollin	Month Day August 17, 20	3. Time of Death 9940 hrs							
1		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D		4c. County of Death							
<i>~al</i>		11175 Georgia Avenue # 720  5. Social Security Number   6. Sex   7. Age (In vrs. last	Silver Spring		Montgomery							
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last	Months Dave Hours									
		Usual Residence of Decedent	, 118.	00/11/19	60 Foreign Virginia							
ow any		1 1 1	own or Location		10d. Inside City Limits							
ne Maryland or 28a-f show	ફ	10e. Street and Number	heaton 10f. Zip Code	100 0	1 Yes 2 X No							
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The marked other than "matural", or items 23a or 28a-f sho or other fraumatic event, the Medical Examiner must be notified at once	Director	11175 Georgia Ave., Apt. 720	20902		ited States							
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 XX Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin?	( Specify Yes or No-	14. Race - American Indian, Black,							
er deat	E	1 Yes 2 XX No	If Yes, specify Cuban, Mexican, Pu	ierto Rican, etc.)	White, etc.							
ars afte tural"	J o	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 18	1 Yes 2 No specify:  6a. Decedent's Usual Occupation (Give kind	of work done	Specify: White Kind of Business/Industry							
72 hou 12 hou 10 "nau	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use									
DO3( within iene.	m d		Independent Contract	or	Swimming Pool novation & Maintenance							
21215-0036 wild be filed within 7 Mental Hygiene. marked other than event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Edwin Allen Hollins, Sr.		ame (First, Middle, Maider [arie Jamisor								
ID 21215-003 should be filed within and Mental Hygiene. 7 is marked other the	L	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number									
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati.		Jimmy D. Hollins, Jr. / Son	10776 Forest Edge C:									
Ore, es lar of Hee If iter		20a. Method of Disposition 20b. Place 1 2	ce of Disposition (Name of cemetery, natory or other place)	ug. 21, 20c.	Location - City or Town, State							
ti Pag rtment rtant:		4 Donation 5 Other Specify: Men 21. Signature of Funeral Sprice Licensee	norial Gardens	2010 Fr	ederick, Maryland							
Bal permi Depa Impo	21. Signature Funeral Service Licensee 22. Name and Address of Facility Restnaven Funeral Services, Skkot Cod 9501 Catoctin Mtn. Hwy. Frederick, MD											
Physician		23a. Part I. Enter the disease of complications that caused the death. Do failure. List only one souse on each line.	not enter the mode of dying, such as cardia	ac or respiratory arrest, she	ock, or heart Approximate Interval							
/Medical		Immediate Cause (Final disease a. Oxycodone intox	ication		Between Onset and Death							
right.		or condition resulting in death)  Due to (or as a consequence of):										
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause										
=	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
iox 68760, eath certificate be executed attending physician and for use as the burial - transit	dical E	d										
50, te be e ysiciar	led je	X UNPENDED X AMENDED #1,23a,27	,28a-f,per ME G908 1	10/4/10 TT								
68760, certificate be nding physic se as the bur	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 Live birth	cy 2 Fetal death 3 Ectopic pre	230	d. Date of delivery Month Day Year							
Box ( e death ce the attence ed for use	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)									
that the dened by the			ting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?							
S, P.O. Lires that the signed by d be detacl	ed by			1 Yes 2	No 3 Probably 4 ✔ Unknown							
ords aw requi as been 2 should	Completed			24a, Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
Rec The 1	S			performed? 1 ✓ Yes 2 No	death? o 1 ✓ Yes 2 No							
ital lician: s certifi	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/	26.Place of Death (Che Outpatient 3 DOA Other Nur									
ing Physi After this	2	1 Yes 2 No	Outpatient 3 DOA Other Nur  Time of Injury 28c. Injury at Work?	sing Home 5 Resider								
ion tendir leath. tor: A	atio	Natural 5 Destin	1 9:!5 am 1 Yes 2 No	unk								
Division of Vital Records, tal or Attending Physician: The law requin as afar death.  In Director: After this certificate has been siled in by the funeral director, page 2 should be	#1, 23a, 27, 28a-f, per ME G908 10/4/10 TT    FFEMALE   23c. If yes, outcome of pregnancy   23d. Date of delivery   Month   Day											
Cospita 1 hours uneral		4 Homicide										
o the E ithin 24 o the F	Medical	Check only one)  2 Wedical Examiner: On the best of my knowledge, done)  2 Wedical Examiner: On the basis of examination and/or and manner stated	eath occurred at the time, date and place, a r investigation, in my opinion, death occurre	nd due to the cause(s) and d at the time, date and plac	d manner as stated. ce, and due to the cause(s)							
F 3 F 3	Me	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month, Day, Year)							
		Mun Branell No	O.C.M.E.	Aug	ust 18, 2010							
5		<ol> <li>Name and address of person who completed cause of death (Item 23a Melissa Brassell, MD Assistant Medical Examiner</li> </ol>	) 111 Penn Street, Baltimore, M	D 21201								
S	ate	31. Date filed (Modern Roy, Wear) 32. Registrar's Signature	Sparke)									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2010 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 19 Day 2010 Year 10:52 Renee Laurin Huard Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Calvert 558 White Sands Drive Lusby cial Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months Hours Min Wash. (Month, Pay 1935) Director 51 D.C. 215-80-7354 Usual Residence of Decedent Department of Health and Mental Hygiene.
Important: If tiem 27 is marked other than "nature."

any injury or other traumatic event. 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20657 558 White Sands Drive USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetologist Beauty Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Everett Gladys George Barbara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie D. Andrew, daughter 3568 Brookside Drive, Chesapeake Beach, MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 08-21-2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Rheumatofil Physician/ disease or condition Means Medical resulting in death) Due to (or as a consequence of) **Examiner** Rhennatuld Preumontts Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit ardiomnopath The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence per 11 ptdem Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mitral prolapse 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After the Funeral Director. 1 Matural 5 Pending 1 Tes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D17245

Registrar

M.D., 19 Chesapeake Beach Rd. East, Owings. MD 20736

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Gerald P. Sterner,

ate filed (Month, Day, Year) AUG 23 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2010 5:55 Pm Rosemary Doris Benton Hyman 16 August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury If Under 1 Year Wicomico 5. Social Security Number 9. Birthplace (State or Foreign . Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Day, Year) 1916 (Month Da May 29, 1 M 2 🔀 F Months Days Hours Mir 94 Washington DC Director 579-01-0781 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified Wicomico Delmar 1 Yes 2 X No MD ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8565 N. Prong Lane U.S.A. 21875 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or à 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify "natural", 3 X Widowed 4 Divorced white Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) injury or other traumatic event, the Homemaker Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosemary Rice Ralph D. Benton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other trau (Son) Frederic B. Hyman 8565 N. Prong Lane Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 🛘 🗀 Burial 2 🖾 Cremation 3 🗖 Removal from State Crematory of Delmarva08-18-2010 4 Donation 5 Other (Specify) Delmar, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home Delmar, DE 19940 13 East Grove Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) 1 ☐ Yes 2.2 9 ☐ Unknown detached the ģ been signed the should be detected to the should be detected to the should be detected to the should be sh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 performed certificate 2 No Yes 2 No 1 Yes 25. Was case referred to predical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manper of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. (Month, Day, Year) injury Natural 5 Pending 2 🗌 No 1 Yes Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 32. Redistrar's Signature

910 Easternshore Dr Salisbury MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesha Thimmarayappa M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Roy Hartwig Johnson . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctor's Community Hospital Lanham If Under 1 Year 7. Age (In yrs. last birthday) Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) Iowa Funeral 1 🗚 M 2 🗆 F March Months Davs Hours Min. 083-18-1286 86 Director Usual Residence of Decedent 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits 10a, State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes XXNo Seabrook MD Prince George's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 9307 Van Buren St. 20706 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 212 5-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Printer Printing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Elsie Hansen Unknown Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris A. Johnson / 9307 Van Buren St., Seabrook, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cem: 8/27/2010 Cheltenham, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD art 1. Enter the disease or complications that caused shock, wheart failure. Litt only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate terval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any loading to immediate cause, Enter Underlying Examiner Due to or as a conse luence of attending physician and for use as the burial-transit Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a conseque Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the control of the cont IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown been signatures should be 24b. Were autopsy findings available prior to completion of cause of death? Shullation has e 2 s autopsy page performed this certificate 1 Yes 2 No Yes Within 24 hours after use....

Within 24 hours after use....

To the Funeral Director. After this certification is the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Tes 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Of Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number

State Registrar DHMH 17 Rev 7/2009

51

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26021

TANOVER

State of Maryland / Department of Health and Mental Hygiene 2010 27923 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 19<sup>ay</sup> 2010 21:44 PM Nathaniel Keith Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton <u>Southern Maryland Hospital</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1 M M 2 □ F Min. Year 9<u>55</u> Director 220-64-9688 54 Maryland Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Manyland Health and Mental Hygiene. Iem 27 is marked other than "natural", or items 23a or 28a-f sho an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Y Yes 2 □ No Maryland
10e. Street and Number Waldorf Charles 10f, Zip Code 10g. Citizen of What Country? Funeral 2453 Streamview Drive 20603 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No 1974 − Year or Dates. 1982 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: 3 Divorced 4 Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 27 is marked other than traumatic event, the Me th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Tele Communications Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Susan Jowers Walter Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 2453 Streamview Dr. Waldorf, Maryland 20603 <u>Darlene Jackson/ Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Aug. 23, 2010 Glen Bernie, Maryland 22. Name and Address of Facility Huntt Funeral Home Signature of Funeral Service License 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and Il-tran Due to (or as a consequence of) resulting in death) Last by the attending physician stached for use as the burial-Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the company of the comp IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 2 No Yes completed filled in by the funeral director, page 2 should be detached g 🗌 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No DIYEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔽 No Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 Natural 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending 1 Yes 2 No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of per eted cause of death (Item 23a) (Type, Print) antre 31. Date filed (Month egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore. Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27924 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Earl Bernard Johnson 2010 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 111 Coleman Rd. Sudlersville Queen Anne's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Months Days Hours Min. (Month, Day, Yea 9/2/1916 93 Director 176-26-6303 Usual Residence of Decedent or 28a-f show should be how...
I and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-1 show 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 🗌 Yes 2 ី No Queen Anne's Sudlersville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21668 USA 111 Coleman Rd permit. Page 1 and 2 should be filed within 72 hours after death v Department of Heath and Mental Hygiene. Important; If tem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 I No Specify If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fabrication Tin Smith Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Emma Harris George Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 390 Millington, MD 21651 Tim Johnson/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Cremation 08/16/2010 Stevensville, MD 22. Name and Address of Eacility Fellows, Helfenbein & Newnam Funeral Home Signature of Funeral Service Licenses 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) heimer 1300 Se LOANS Medical as a consequence of): Examiner Examine physician and s the burial-trans Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as ase signed by the a Completed by

page 2 should Jas To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director,

Be

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Medical Certificate:

Consumption link appointings	b. —				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ	uence of):			
that initiated events resulting in death) Last	C. Due to (or as a consequ	uence of):			
	d				
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregna 1  Live Birth 2  Feta 4  Pregnant at time of c	Il death 3 🔲 Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions	•				d tobacco use contribute to the cause of death?  ☐ Yes 2 1.No 3 ☐ Probably 4 ☐ Unknown
					rtopsy prior to completion of cause of death?
25. Was case referred to medical			26. Place of Death (Che	ck only one)	
examiner? 1 🗆 Yes 🙎 No	Hospital: 1  Inpatient 2	ER/Outpatient 3 .	OOA Other: 4 \( \sum \) Nursing H	lome 5 Re	esidence 6 Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describ	e how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	1 29a Place of Injury - At he		ry, office		n (Street and Number or Rural Route Number, Town, State)
(Check 2 Medical Exan	niner: On the basis of examination	n and/or investigation, in	my opinion, death occurred	at the time, dat	cause(s) and manner as stated. te and place, and due to the cause(s) and manner stated. the cause(s) and manner as stated.
29b. Signature and title of certifier		29	c. License number		29d, Date signed (Month, Day, Year)

State Registrar person who completed cause of death (Item 23a) (Type, Print)

10-06132 Louis Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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August 12, 2010	3. Time of Death 2111 hrs ounty of Death nce George's  YYYYY) 9. Birthplace (State or Foreign NORTH Country) CAROLINA  10d. Inside City Limits 1
Medical Examiner  LOUISE  JONES  4a. Facility Name (if not institution, give street and number)  7628 Allendale Drive  Funeral Director  5. Social Security Number  238-70-4583  1 M 2XF  64  Yrs.  4b. City, Town, or Location of Death Hyattsville  Prince  Months  Days  Hours  Min.  JAN 22 1946  Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location	ounty of Death nce George's  YYYYY 9. Birthplace (State or Foreign NORTH Country) CAROLINA  10d. Inside City Limits 1 Xyes 2 No
4a. Facility Name (if not institution, give street and number) 7628 Allendale Drive  5. Social Security Number 238-70-4583  1 M 2 X F  64  Yrs.  4b. City, Town, or Location of Death Hyattsville  Prince  4c. County  Prince  15 Social Security Number 238-70-4583  1 M 2 X F  64  Yrs.  4c. County  Prince  16 Sex  And If Under 1 Year  If Under 24Hrs.  And If Under 24Hr	9. Birthplace (State or Foreign ORTH CAROLINA  10d. Inside City Limits 1 X Yes 2 No
Funeral Director  5. Social Security Number 238-70-4583   7. Age (In yrs. last birthday)   1 Under 1 Year   1 Under 24Hrs.   8. Date of Birth (MM/DD/Y Months   Days   Hours   Min.   JAN 22 1946   Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   10c. City, Town or Location   10c. City   10c.	9. Birthplace (State or Foreign NRTH CAROLINA  10d. Inside City Limits  1 X Yes 2 No
Director  238-70-4583  1 M 2 F 64  Yrs. Months Days Hours Min.  JAN 22 1946  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	6 Foreign ORTH CAROLINA  10d. Inside City Limits 1 X Yes 2 No
Director  238-70-4583  1 M 2 F 64  Yrs. Months Days Hours Min.  JAN 22 1946  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	6 Foreign ORTH CAROLINA  10d. Inside City Limits 1 X Yes 2 No
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 X Yes 2 No
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 X Yes 2 No
	1 XYes 2 No
MD PRINCE GEORGE'S LANDOVER	
106. Zip Code 109. Citizen of	of What Country?
g 80 m o o	•
है है है   7628 ALLENDALE DRIVE   20785   USA	
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	. Race - American Indian, Black,
Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
The second of th	ecify: BLACK
To Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Work	d of Business/Industry
To be dedon't s Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Ostan Occupation (Give kind of work done during most of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surnal Completed)  18. Mother's Name (First, Middle, Maiden Surnal Completed)  18. Mother's Name (First, Middle, Maiden Surnal Completed)	
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The state of the s	Town State Zin Code
7 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or	
DOUGLAS JONES/HUSBAND  7628 ALLENDALE DRIVE LANDOVER, MARY  20b. Place of Disposition (Name of cemetery, Carpetter)  20c. Method of Disposition  20c. Location (Name of cemetery)  20c. Location (Name of cemetery)	RYLAND 20785 ration - City or Town, State
DOUGLAS JONES/HUSBAND  7628 ALLENDALE DRIVE LANDOVER, MARY  20a. Method of Disposition  1 ABurial 2 Cremation 3 Removal from State  HAMILTON CAPPENS  8/21/2010 HITIS	ation - City or Town, State
200. Place of Disposition (Name of Certificity)  Light House of Disposition (Name of Certificity	SON, NORTH CAROLINA
HAMILTON GARDENS 8/21/2010 WILSO  1	S FUNERAL HOME
7474 LANDOVER ROAD LANDOVER, MAI	
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or	or heart Approximate Interval
failure. List only one cause on each line.	Between Onset and Death
Examiner Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):	333
bue to (or as a consequence or).	
Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
if any, leading to immediate  Due to (or as a consequence of):  Compared to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	12
events resulting in death) Last Due to (or as a consequence of):	
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events resulting in death) Last    Value   Val	
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So the least of th	onth Day Year
past 12 months?    The birth   Control   Contr	
World September 1	
Contributing to death but not resulting in the underlying cause given in Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	contribute to the cause of death?
CHF  CHF  CHF  CHF  CHF  CHF  CHF  CHF	o 3 Probably 4 Unknown
Spropsy to the policy of the p	24b. Were autopsy findings available prior to completion of cause of
performed?	death?
Yes 2 ✓ No 1 Yes 2 ✓ No 25. Was case referred to medical 26.Place of Death (Check only one)	1 Yes 2 X No
25. Was case referred to medical 26. Place of Death (Check only one)  25. Was case referred to medical examiner?  Hospital: 1 Inputient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence	
The state of Light of	occurred
Natural 5 Pending 1 Yes 2 No 2 Accident Investigation	
Solicide  6 Could not be  28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Nu or Town, State)	Number or Rural Route Number, City
25. Was case referred to medical examiner?  1 V Yes 2 No  25. Was case referred to medical examiner?  1 V Yes 2 No  26. Place of Death (Check only one)  27. Manner of Death  1 V Natural 5 Pending  28a. Date of Injury  (Month, Day, Year)  28b. Time of Injury at Work?  1 Yes 2 No  28b. Limit of Injury at Work?  28c. Injury at Work?  28d. Describe how injury occ (Month, Day, Year)  28d. Place of Injury  28d. Injury at Work?  28d. Describe how injury occ (Month, Day, Year)  28d. Place of Injury  28d. Injury at Work?  28d. Describe how injury occ (Month, Day, Year)  28d. Place of Injury  28d. Injury at Work?  28d. Describe how injury occ (Month, Day, Year)  28d. Place of Injury  28d. Injury at Work?  28d. Describe how injury occ (Month, Day, Year)  28d. Place of Injury  28d. Injury at Work?  28d. Describe how injury occ (Month, Day, Year)  28d. Place of Injury - At home, farm, street, factory, office building, etc.  28d. Location (Street and Nu or Town, State)	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man	
특별 등 기계 one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, an	and due to the cause(s)
and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date s	e signed (Month, Day, Year)
O.C.M.E. August 1	t 17, 2010
30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day Year) 32. Registrar Signatural Si	

		For State	Pleas	se Type or Pri State of M		d / Dep	artment of I	Health a					e.	07006
		State Registrar  1. Decedent's Nam	- /First Middle	Looth		Ce	ertificate of	Death	12	. Date of De	Reg. No	201	U	3. Time of Death
Physicia	an	Robert I		,					'	Month 8	Da 20		ear	0600 M
/Medic Examin				, give street and number	·)		4b. City, Town, o	or Location of	of Death		1	. County of		C 400
Lxaiiiii	CI.			ew Circle			Owing					Calve	rt	
Funeral		5. Social Security N	1	6. Sex 7. A		last birthda	y) If Under 1 Year Months Days		Min.	Date of Bi (Month, D	rth a <i>y</i> , <i>Y</i> ea <i>r</i> ,	) 9.		
Director		215-42-6		LaL IVI LUI	66	Yrs.			I	ebruar	y 13,	1944		PA
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hours after death with the Maryland hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	Director	MD	Calve	rt		Owing	S							1 ☐ Yes 2X No
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ath w		8440 Mea	adow Vi	ew Circle		20736						ted S		
er de items	Funeral	<ol> <li>Marital Status</li> <li>Never Marr</li> </ol>	ind ON Mouri	12. Was Deceden Armed Forces ed 1 □Yes 2 🔀	?	S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R		igin? (Spec n, Puerto Ri	can, etc.)	0-	14. Race - Black, \			
irs aft	by	3 Widowed		If Yes, Give Year or Dates			1 □Yes 2 No	Specify:				Specify:	Wh	ite
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thould nd Me mark matic	2	Robert I				19h. Ma	iling Address (Stree	_		choff1		or Town. St	ate. Zip	Code)
nd 2 s ulth ar 27 is r trau		Robin Ke					Meadow V							
s 1 ar of Hea item othe	Ì	20a. Method of Dis	position		20b. F		position (Name of ematory or other pla		Da			ocation - Ci		wn, State
Page nent c int: If			☐ Cremation 5 ☐ Other (S)	3 ☐ Removal from State pecify)	9		ematory		8/22/	2010	C	linto	. N	MD
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, Its Maxical once.		21. Signature of Fe	uneral Service	icensee			22. Name and Addr	ess of Facilit	ty Lee	Funer	al H	Iome C	alve	ert, P.A.
3 85 E 8 8		GAR	J. Go:				8125 Sout					Owin	gs,	
Physician		23a. Part 1. Enter shock, or hea Immediate Cause disease or condition	(Final	complications that cause only one cause on each	ed the deat line.		enter the mode of dy		cardiac or	respiratory	arrest,			Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		Due to (or a	s a conseq									
uted J Insit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease of that initiated event	nmediate erlying r injury	Due to (or a	s a conseq	uence of):								
e executed ian and irial-transit	Еха	resulting in death)	s Last	C Due to (or a	s a conseq	uence of):								
ate be nysicia	ical			d										
ertifica ling ph e as th	Med	IF FEMALE:												
The law requires that the death certificate be ate has been signed by the attending physicis bage 2 should be detached for use as the bur	Physician/Medica	23b. Was deceder in the past 12 1 Yes 2 9 Unknown	! months? □ No	23c. If yes, outcom  1  Live birth  4  Pregnant  9  Unknown	2 Feta	death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)					23d. Date of Month		ery Day Year
s that ned b	by Pr	Part II. Other signi	ficant condition	ons contributing to death	but not res	ulting in the	underlying cause g	iven in Part I	l.	23e. Did	tobacco	use contrib	ute to th	ne cause of death?
quires en sign uld be										1 🗆	Yes 2	2 □ No 3	☐ Prob	bably 4 Unknown
law requir as been s 2 should I	Completed									24a. Wa	s an opsy	24b. We	ere auto	psy findings available mpletion of cause of
The l	mo									per	formed?	dea	ath?	2  No
certificate	Be (	25. Was case refe examiner?	rred to medical						e of Death	(Check only	one)			
Physician: this certific ral director,	ဥ	1 ☐ Yes 2 🕽	`			·	IEII 3 LI DOA		ursing Hom			6 Other		y)
Jing I	ion:	27. Manner of Dea 1 Natural	τη 5 □ Pendin investig		jury Da <i>y, Y</i> ea <i>r)</i>	28b. Time Injur	y Wo	uryat ork? ⊒Yes 2□		a. Describe	e now inji	ury occurred		
death ctor: y the	ficat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could i	not be 200 Place of I	niury - At he	ome, farm,	street, factory, office			3f, Location	(Street a	and Number	or Rura	al Route Number,
s after s all Directory	Certification:	4 Homicide	determ	building,	etc. (Special	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To				,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)	16 Certifyir 2 Medical	g Physician: To the bes Examiner: On the basis and manner:	of examina	owledge, de ation and/or	eath occurred at the r investigation, in my	time, date a opinion, de	nd place, a ath occurre	nd due to the	e cause e, date a	(s) and man	ner as s d due to	stated. o the cause(s)
Viithi Viithi Com	ž	29b. Signature and	title of certifie				29c. Licer	nse number			29d. D	ate signed (	Month,	Day, Year)
11.141		1 AM 1017324 812010												
10		1)	A.	who completed cause of	death (Iter	m 23a) (Typ	e, Print)		I	FINCE	T		1.	
Sta	te	31. Date filed (Moi	nth, Day, Year)	32. Regis	strar's Signa	ature	INTERVIAN	مر ل	T, 1	VINCE		1920	M	1)
Registr		AUG 23	0010		pa									
OHMH 17 Rev 1/2	001			Janes John	1900	2,00					-			

DHMH 17 Rev 1/2001

HERESA LMGANA Maryland 21215-0036

THER

Baltimore,

Box 68760

Division of Vital Records, P.O.

10-06519 Glenn McClure Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

F	- For State Registrar	Certificate of Death	7.0	eg. No. 2010 2792			
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	C1	2. Date of Dea Month August 29	Day Year			
· \	Glenn Curtis Mc  4a. Facility Name (if not institution, give street and number)			4c. County of Death			
	McCready Hospital ER	Crisfield	1	Somerset			
Director	175-34-2626 1XM 2F	e (In yrs. last birthday)  66 Yrs. If Under 1 Year Months Days	Hours Min. 8. Date of Bit 09/07	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign New Park Country) Mary Land			
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits			
<b>\$</b>	PA Lancaster	Peach Bottom		1 Yes 2XX No			
ne Maryland or 28a-f show <u>fied at once.</u> Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Country?			
th the 323 or notifie	2613 Robert Fulton Highwa			United States			
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, and theath and Mental Hygiene, or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces	If Yes, specify Cuban,	eanic Origin? ( Specify Yes or No Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.			
s after de rral", or niner mu by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates	X No	specify:	Specify: White			
nours a	15. Decedent's Education (Specify only highest grade con	during most of working life.		16b. Kind of Business/Industry			
36 in 72 h han "i dical F	Elementary/Secondary (0-12) College (1-4 or	5+)		Government			
5-0036 ed within 72 hour tygiene. other than "natu he Medical Exan Completed	12 17. Father's Name (First, Middle, Last)	Geodetic Techr	ITC TAII 8.Mother's Name (First, Middle, I				
21215-0036 Juld be filed within 7 Mental Hygient and an arked other than in event, the Medica for Be Comple	Rex McClure		Esther Page T				
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other if injury or other traumatic event, the Med	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street 2613, Robert Fu Peach Bottom,		nber, City or Town, State, Zip Code)			
and 2 sho realth and item 27 is traumati	Mary L. McClure / Spouse  20a. Method of Disposition	20b. Place of Disposition (Name of cem	etery, Date	17563  20c. Location - City or Town, State			
nore ages   ant of F	1 X Burial 2 Cremation 3 Removal from St	crematory or other place) Conowingo Baptist Cemetery	September 2, 2010	Conowingo, Maryland			
Baltimore, Demit. Pages I at Department of Hee Department of Hee Injury or other tr	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	22. Name and Address	of Facility Crouch Fun				
	Robert T. Crouch, per DVR  23a. Part I. Enter the disease, or complications that caused			rth East, Maryland			
/Medical	failure. List only one cause on each line.			Between Onset and			
	Immediate Cause (Final disease or condition resulting in death)  a. <u>hyperten</u> : Due to (or as a const	sive atherosclerotic	cardiovasculai	disease sour			
	Sequentially list conditions, b						
nine	If any weding to immediate Due to (or as a const cause. Enter Underlying Cause (Disease or injury that initiated	e Juence of Jr					
ted Insit	events resulting in death) Last Due to (or as a cons	equence of):					
	X UNPENDED X AMENDED			4.0.			
60, cate be execu physician and the burial - tra	F FEMALE: 23c, If yes, outcome	per FD 23a.PII.27.pe ne of pregnancy	r ME g908 10/8	/ 10 TT 23d. Date of delivery			
certific cer	3b. Was decedent pregnant in the past 12 months?	time of death 5 Other (Specify)	Ectopic pregnancy	Month Day Year			
). Box 687 the death certific by the attending priched for use as the	1 Yes 2 No 9 Unknown 9 Unknown	time of death 5 Other (Specify)					
Records, P.O. In the law requires that the care has been signed by the page 2 should be detached on the completed by Ph		n but not resulting in the underlying cause gi		obacco use contribute to the cause of death?  s 2 No 3 Probably 4 ✔ Unknown			
Vital Records, P.O. vysician: The law requires that this certificate has been signed be director, page 2 should be detac	Chronic alcoholism		24a, Was				
Records, The law require ficate has been signage 2 should be			autop perfo	prior to completion of cause of death?			
Reilificate	25. Was case referred to medical	26 Place	1 ✓ Yes of Death (Check only one)	2 No 1 Yes 2 No			
Vital visician ysician director	examiner?		Whor -	Residence 6 Other:			
on of Vita on of Vita anding Physicia tth. r: After this ce to funeral direct	27. Manner of Death  1 X Natural  5 Deading  28a. Date of Inju. (Month, Day, Y	iry 28b. Time of Injury 28c. Injury	at Work? 28d. Describe I	how injury occurred			
Sion strend death ctor: cy the f	2 Accident Investigation		es 2 No				
Division o popial or Attending nours after death neral Director: Aft filled in by the fune Certification:	Suicide Could not be determined (Specify)	jury - At home, farm, street, factory, office bu	ilding, etc. 28f. Location (\$ or Town, S	Street and Number or Rural Route Number, City state)			
Hospit Hour Funcra ely fill	Ponicide Ponicide	y knowledge, death occurred at the time, dat	e and place, and due to the caus	se(s) and manner as stated.			
Division of Vital Records, P.O. Box 687  To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death or affer this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/		mination and/or investigation, in my opinion,	death occurred at the time, date	and place, and due to the cause(s)			
	29b. Signature and title of certifier	29c. License		29d. Date signed (Month, Day, Year)			
<b>─</b> ,	Theodore W. Ling Jk.	o.c.N	I.E. OCME	August 30, 2010			
1	30. Name and address of person who completed cause of completed the Theodore M. King, Jr., MD. Assistant M.		et, Baltimore, MD 21201	1			
State							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician Charles C. Mc Glaughlin 12:40 Augusá 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bel Year Air If Under <u>Harkord</u> Brightview Assisted Living In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 2□ F Months Days Hours Min. 91 188-09-5371 Maryland Nov 02. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Middle Examinations as the matthed at 1 X Yes 2 ☐ No Director Havre de Grace Harkord Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21078 United States 712 St. James Terrace Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1943-46 Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MD National Guard Comptroller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lutie Irene Kendall Charles Calvin Mc Glaughlin ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 712 St. James Terrace, Havre de Grace, MD 21078 Cheryl M. Harris / Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aberdeen, Maryland Harford Memorial Grds 08/25/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final end 5. was deme **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐Yes 2 ☐No 1 ☐ Yes Vital Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ Division of After this funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident hin 24 hours after death the Funeral Director: filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely

State Registrar

29b. Signature and title of certifier

within To the

29c. License number

P32255

82/11 MA

29d. Date signed (Month, Day, Year)

24

20/2

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Marylar		artment of rtificate of			Reg. N	010	27930		
	Physicia	an	1. Decedent's Name (First, Middle, Last)	$\sim$ .				2. Date of D	Day		3. Time of Death		
	/Medic	al	4a. Facility Name (If not institution, give si	Micguire		4h City Town	or Location of Dea	August	August 14 2010 995 AM 4c. County of Death				
	Examin	er	41 1 0	spital Cer	tar	Che	1 1.			Kent			
	Funeral		Social Security Number     6. Sex	7. Age (In yrs.		If Under 1 Yea Months Day	r   If Under 24 Hr	s. 8. Date of B	irth Dav. Year)		ace (State or Foreign		
Territoria.	Director		219-44-1491	M 20XF	63 Yrs.	Worldis	o Hours IIII	08/18/	1946		tertown		
	and ww		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				1	Od. Inside City Limits		
	Maryl f sho	ğ	MD Vont	Mon	ton						1 ☐ Yes 2 ☐ No		
	r 28a	irec	MD Kent  10e. Street and Number	Wor	LOII	10f. Zip Code			10g. Citi	izen of What Coun	try?		
	th with	alD	10713 Horseshoe La	ne		21678			USA				
	r dear	nei	11. Marital Status	2. Was Decedent Ever in U	l.S. 13.	Was Decedent of	Hispanic Origin? Jban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Americ Black, White, e			
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Evaniner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 XNo If Yes, Give Year or Dates:		1 □Yes 2 □ N	o Specify:			Specify: Whit	e		
21215-0036	hour stural	edk	15. Decedent's Educa		16a. Dece	dent's Usual Occ	upation		16b. Ki	ind of Business/Inc	lustry		
215	hin 72 9. an "na Medik	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	`life.	DO NOT use reti	,	rorking					
21	ygiene /giene er tha	Con	11		Wait	ress/Hos				staurant			
Maryland	be file	Be	17. Father's Name (First, Middle, Last)					ame (First, Middi	e, Maiden	Surname)			
ryla	d Mer d Mer narke	٦	Maynard Porter Sr.	a Deleth	10b Maii	na Addrosa (Stro	Clara R		phor City o	or Town, State, Zip	Code		
Mai	d 2 sh Ith an 17 is r traur		19a. Informant's Name/Relationship (Type Thomas McGuire - Hu	•		,	hoe Lane		-		0000)		
	s 1 an if Hea item 2		20a. Method of Disposition			osition (Name of matory or other p		Date		ocation - City or To	wn, State		
E	Pagestent o		1 ☐ Burial 2 【A Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State			i i	/16/2010	Ste	evensvill	e. MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantreer must be notified at once.	l	21. Signature of Funeral Service License	- Contract of the Contract of						enbein &			
<u> </u>	89 = 88		Buch J.	refile			r Road C						
			23a. Part 1. Enter the disease, or complete shock, or heart failure. List only one	cause on each line.							Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	ACUTE M	YOCA	RIVIAC	INFAM	ZCMON					
ď	/Medical Examiner		resulting in death)	Due to (or as a consec ATHERUSC	quence of):	TIC CA	12/01/01/18	LSCIAL A	r D	ISEASE			
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):	ILC CA	10/3/0 4/	(SCOLON	,		-		
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
oʻ	e exec ian ar ırial-tr		resulting in death) Last	Due to (or as a consec	quence of):			-					
8760,	cate be executed physician and the burial-transit	dical	d.							<u> </u>			
9		/Mec	IF FEMALE:	c. If yes, outcome of pregn	ancv					22d Date of doline	271/		
Вох	death certif e attending id for use as	cian	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of	al death 3	☐ Ectopic pregna☐ Other (specify)				23d. Date of delive Month	Day Year		
P.0.	the d by the ached	Physician/Me	1 □Yes 2 M/No 9 □ Unknown	9 ☐ Unknown									
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by PI	Part II. Other significant conditions conf	•	•		-				ne cause of death?		
Division of Vital Records,	equire en sig ould b	ed b	CHRONIC OBSTRUCT	IVE PULME,	NARY	DISEASI	<u> </u>	_ 15	Yes 2	□ No 3X Prol	pably 4 🗌 Unknown		
ecc	law re as be 2 sho	Completed	HYPERIENSIVE CARD	iovaschlar	DISER	SE		_ 24a. Wa	topsv	prior to co	psy findings available mpletion of cause of		
<u>=</u>	The tate pag	Com						pe 1 □ Yes	formed?	death? 1 ☐ Yes	2 <b>X</b> No		
Vita	ding Physician: Th. h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	oppital:			N41	eath (Check only					
of	Phys this	<u>د</u>	1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	IN 3 LI DOA	4 LI Nursing	Home 5 KRe		6 ☐ Other (Special	(y)		
on	fing After fune	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	Injury		njury at /ork? □Yes 2 □No	ZGG. DGGGND	o now inju	, , , , , , , , , , , , , , , , , , , ,			
/isi	Attending r death. ector: After by the funer	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	nome, farm, st	reet, factory, offic	e			nd Number or Run	al Route Number,		
á	al or s afte al Dire	Certification:	4 Homicide	building, etc. (Spec	iiy)			City of 1	own, State	9)			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ical	(Check only Medical Examin	ician: To the best of my kn er: On the basis of examin									
	thin 2.	Medical	29b. Signature and title of certifier	and manner stated.		29c tice	ense number		29d. Da	ate signed (Month,	Day, Year)		
	So <sub>r</sub> ™ So <sub>r</sub>		A A	The m	)	-	00415	87	Ι.	8-16-			
	5		30. Name and address of person who con				/ 1	- /	· _ ·	J 14 6			
	TA		Dr. Noble 122 Spec				and 21620	)					
	Sta	te	31. Date filed (Month, Day, Year)	32. Fegistrar's Sign		(ag)							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar Certificate of Death Reg. No. 2010 279								27931				
	Diam'r.	,	Decedent's Name (First, Middle, Last)				2. Date of Di Month			Death 3. Time of Death			_	
	Physicia Medic		William Joseph Pitner				Augus					2, 201		1
	Examin	er	4a. Facility Name (if not institution,				4b. City, Town, o		of Death			County of Deat		
	Funeral		1102 Wrighton 5. Social Security Number	6. Sex 7. Ag	e (In yrs. last	birthday)	If Under 1 Year	If Under	r 24 Hrs.	8. Date of Birl	th	9. Bir	hplace (State or Foreign	n
-	Director		577-48-9015	1 😿 M 2 🗆 F	72	Yrs.	Months Days	Hours	Min.	(Month, Da 08/05/	1938	Was	shington, D	C
	nd how at	٦	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	cation						10d. Inside City Limits	
	faryla Ba-fs tified	ecto	Maryland Cha	rles	Br	yans	Road						1 ☐ Yes 2🏗 No	0
	the N	ig	10e. Street and Number	2.2.00		<i>y</i> 4110	10f. Zip Code				10g. Cit	izen of What Co	untry?	
	ns 23 must	Funeral Director	6-H Hampton C					616		1		USA		
Maryland 21215-0036	s after deat al", or iter Examiner	þ	<ul><li>11. Marital Status</li><li>1 Never Married 2 X Marri</li><li>3 Widowed 4 Divorced</li></ul>	12. Was Decedent E Armed Forces? 1  Yes 2  If Yes, Give Year or Dates.	Ever in U.S. No		Vas Decedent of H f Yes, specify Cuba			cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify:		
2-0	"natur	plete	15. Deceden (Specify only higher		cation 16a, Dece			edent's Usual Occupation thind of work done during most of working			16b. Kind of Business Industry			
121	thin 72 the. than '	Completed	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use				O NOT use retired)	se retired)				House Painting		
d 2	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	10 17. Father's Name (First, Middle, Li	lst)		-	Painter	18. Moth	her's Name	(First, Middle,				
/lan		욘	John Pitner					Ne	ellie	Barr	nes			
lan			19a. Informant's Name/Relationsh	p (Type, Print)		19b. Mailin	g Address (Street	and Numb	oer or Rural	Route Numbe	r, City or	Town, State, Zij	Code)	
e, N	and 2 Health em 27 ther to		Doris Pitner/S  20a. Method of Disposition	pouse	20h Plac		Box 854	, Bry				0616 ocation - City or	Town Ctate	
nor	age 1 ant of 1 it. If it.		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S)		cem	etery, cren	natory or other place Ld-Echols			6/2010		•	Hall, MD	
Baltimore,	permit. Pa Departme Importan any injur.		21. Signature of Funeral Service Li		DITH						-		1, MD 20622	
	0 5 5 C		23. Part 1. Enternal e disease, or	complications that caused	d the death. D					10,000		tte Hal	1, MD 20622 Approximate	<u>2</u>
F	Physician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Interval Bef Onset and Onset an								Interval Between Onset and Death			
- A	Medical Examiner													
	roate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or iinjury	a conecçuer	RECUES RECUE									
		that initiated events resulting in death) Last  Due to (or as a consequence of):										_		
760	cate be physic the bi	edical		d										_
89	ath certific attending   I for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	/						23d. Date of de	livery	
D. Box	or Attending Physician; The law requires that the death certificate death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a			Ectopic pregnand Other (specify)	су				Month	Day Year	
ds, P.O.	requires that been signed should be de		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown								'n			
Records,	The law re ate has be page 2 sho	Completed by								24a. Was autor perfo 1  Yes	osy ormed?/	prior to death?	topsy findings available completion of cause of	i
ta	sician; The certificate rector, pag	B	25. Was case referred to medical examiner?	Hospital:			26. P	~ ~	ath (Check				Daughter's	
of Vital	Physi rrthis o	e: 10	1 ☐ Yes 2 🗷 No 27. Manner of Death	1 Inpati 28a. Date of inju	ent 2 ER	b. Time of	t 3 DOA 28c. Injur	4 ∐ N		me 5 Resid			Residence	<u>e_</u>
ouo	Attending Phy or death. ector: After this by the funeral d	icat	1 → Natural 5 ☐ Pending 2 ☐ Accident Investig	ation	(Month, Day, Year) injury work?  M 1 ☐ Yes 2 ☐ No									
Division	al or Atte s after de il Directo ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e. Place of Inju	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	29a. Certifier (Check Check Ch								ted.			
	To t with To t		29b. Signature and title of certifier  Pttt	nue	- N	1D	29c. Licens	e number 4037	70			te signed (Mont.	n, Day, Year)	
pn	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Peter L. Wisniewski, M.D 110 Hospital Rd., Prince Frederick, MD						MD 2067	8						
	Sta Registra		31. Date filed (Month, Day, Year)		ar's Signature					-				i i

DHMH 17 Rev 7/2009

		1 - For State Registrar	State of Mai	Cei	rtificate of		Re	2010	27932	
Physic	ian	1. Decedent's Name (First, Middle, L.  M. Doris Piero					2. Date of Deat Month	Day Yea		
/Med	ical	4a. Facility Name (If not institution, gi	4b. City, Town, or Location of Death			17, 2010 4c. County of De	2:30 a <sup>M</sup>			
Exami	ner	Golden Crest Ass	Hampstead			Carroll				
Funeral Director		216–18–3538	Sex 7. Age 1 N 2 1 N 2 1 N 2 1 N 2 1 N 2 1 N 2 N 1 N 2 N 1 N 1	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,		Sirthplace (State or Foreign Country)	
land	7	Usual Residence of Decedent  10a. State 10b. County	·	10c. City, Town or Lo	ocation				10d. Inside City Limits	
Mary a-fsh	to	Maryland   Carroll		Hampstead	đ				1 □ Yes 2 No	
h with the 23a or 28	al Director	10e. Street and Number 17916 Marshall M	ill Road		10f. Zip Code 21074			og. Citizen of What nited Sta		
Ind 21215-0036  be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, it a Modern Examination and a	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1  Yes  No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 □Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ai Black, Wi Specify:		
21215-0036  within 72 hours aft giene. er than "natural", or it e Medie	Completed	15. Decedent's Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give		oation during most of workir d)	ng	16b. Kind of Busines banking	ss/industry	
laryland 2: Should be filed v and Mental Hygie Is marked other I aumatic event, It	To Be Co	11   CIE  17. Father's Name (First, Middle, Last)  Lee Wicker Hunter			18. Mother's Name (First, Mid  Ida Belinda P			dle, Maiden Surname)		
Baltimore, Maryland bernit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event any injury or other traumatic event once.	F	19a. Informant's Name/Relationship Thomas H. Pierce	(Type. Print)		-	and Number or Rura	l Route Number	; City or Town, State		
imore Pages 1 a ment of He ant: If item ury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐ Removal from State	20b. Place of Dispo cemetery, crei Pleasant		nagas	+ 20	20c. Location - City REisterst		
Baltimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Lionsee  22. Name and Address of Facility  Eline Funeral Home  M01072 934 S. Main St., Hampstead, Md. 21074								
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence):  Due to (or as a consequence):								
A.S. 10	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Dus to (or ac a	consequence of):						
68760, ificate be executed g physician and s the burial-transit	ical Exa	resulting in death) Last	Due to (or as a d	consequence of):						
BOX	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	у		23d. Date of Month	delivery Day Year	
ecords, P.O. law requires that the de as been signed by the. 2 should be detached	by							acco use contribute to the cause of death?  2 ★ No 3 □ Probably 4 □ Unknown		
The ate h	Completed						24a. Was ar autops perform 1 □ Yes 2	v prior	autopsy findings available to completion of cause of ?	
VITAI sician: T certifica rector, pa	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death			Assuta	
g Physicar this teral dil	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day,	28b. Time o	11 3 DOA	4 LI Nursing Hor		ence 6 Other (S	pecify) Lyuins	
SIOT endin eath. or: Aff	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not I	on	Year) Injury		Yes 2□No				
DIVISION OT VITA ttal or Attending Physician: rs after death. al Director: After this certificate in by the funeral director, reled in the funeral director, release in the funeral director in the funeral director director, release in the funeral director	Certification:	4 ☐ Homicide determined	building, etc.				City or Towr	n, State)	Rural Route Number,	
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ti	Medical	one)	hysician: To the best of miner: On the basis of e and manner state	examination and/or in	vestigation, in my	opinion, death occurr	ed at the time, d	ate and place, and o	due to the cause(s)	
M2 6 6	2	29b. Signature and title of Sertifier	ella 1	M		36112		9d. Date signed (Md 8-17-/		
5		30. Name and address of person who D. Alexander Rock	·	ath (Item 23a) (Type, 231 Northw		il Uamach	-024 ru	21074		
St	ate	31. Date filed (Month, Day, Year)	32. Registrar'	s Signature		rr nampst	ead, MD	210/4		
Regist	rar	AUG 19	2010 Lener	n B. A	backer					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ JOHN ANTHONY PHILLIPS Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 20-44-0756 Usual Residence of Decedent 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location Director PRINCE GEORGE'S MD GLENARDEN 10e. Street and Number 10f. Zip Code Funeral 7939 POLK STREET 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 X Yes 2 No NAVY If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed 3 - Widowed 4 T Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F 7 is marked of 2 RANDOLPH BOWES

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

20a. Method of Disposition

Ronnie Washington /Brother

1 Durial 2 Termation 3 Removal from State

 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No Specify: BLACK Specify: 16b. Kind of Business Industry (Give kind of work done during most of working

ANN BROWN

22. Name and Address of Facility J. B. JENKINS FUNERAL HOME

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7939 POLK STREET GLENARDEN, MARYLAND 20706

7474 LANDOVER ROAD LANDOVER, MARYLAND

2. Date of Death

8. Date of Birth
(Month, Day, Year)
JULY 20 1954

Day

2010

4c. County of Death

10g. Citizen of What Country?

PRIVATE

20c. Location - City or Town, State

RIVERDALE, MARYLAND

Approximate Interval Between Onset and Death

PRINCE GEORGE'S

VIRGINIA

6:00

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 No

Month

AUGUST

Min.

Department of Health an Important: If item 27 is any injury or any injur Physician/ Medical

Examiner -tran certificate be Division of Vital Records, P.O. Box 68760 that the death

Physician/Medical Examiner ģ Completed Certificate: To Be Medical

23a. Part 1. Enter the resease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart f-ilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	CENTROLION REPROD	ED 87 MEDICAL ELEM	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year
1	ontributing to death but not resulting in the underly Chronic renderly couple (when we have			
25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined		28c. Injury at work? 1 □ Yes 2 ▼ No actory office	ne 5  Residence  8d. Describe how inj  5	Fell From Standing
(Check 2 Medical Exami	sician: To the best of my knowledge, death occur ner: On the basis of examination and/or investigation se Practioner: To the best of my knowledge, death	n, in my opinion, death occurred at t	he time, date and pla , and due to the caus	ce, and due to the cause(s) and manner stated

5 Woduval

Due to (or as a consequence of):

20b. Place of Disposition (Name of

cemetery, crematory or other place,

RIVERDALE CREMATORY 18/23/2010

330

23d. Date of delivery	
Month Day Year	
23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown	
24a. Was an autopsy performed?  1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No 2 ☒ No 1 □ Yes 2 ☒ No	
only one)	
ne 5 🗆 Residence 6 🗀 Other (Specify)	
3d. Describe how injury occurred  Subject Fell From Standing	
8f. Location (Street and Number or Rural Route Number, City or Town, State) 1939 POLK STYEET, MD	
due to the cause(s) and manner as stated.	

Registrar DHMH 17 Rev 7/2009

State

To the Hospital or Attending Physician:

3001

of person who completed cause of death (Item 23a) (Type, Print)

M

Physiciar		State Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of		2. Date of Death	Day Yea	27934 3. Time of Death
/Medica	1	William Edward Phil  4a. Facility Name (If not institution, give street and		Ab City Town	r Location of Death	August 1	4c. County of D	7:10 pM
Examine	r	308 E. Lillian Stre	,	Hebr			Wicom:	
uneral rector	2	5. Social Security Number 6. Sex 1 ☑ M 2 □ I	7. Age (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 0/27/19	Sar) 9. 1 Ma	Birthplace <i>(State or Foreig</i> Country) aryland
-f show	l	Usual Residence of Decedent   10a. State   10b. County	10c. City, Town of Hebro					10d. Inside City Limits
st bu noti	Funeral Director	10e. Street and Number 308 E. Lillian Street		10f. Zip Code 2183	0	10g	. Citizen of What	Country?
o,"le	2	1 ☐ Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	s 2 No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race - A Black, W Specify:	merican Indian, Ihite, etc. White
atri d	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	ed) ()	Decedent's Usual Occup Give kind of work done life. DO NOT use retired Truck Drive	during most of workiกยู d)	g 16	th. Kind of Busine	,
ent, II	Se P	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	iden Surname)	
arked atic ev	9 0	William Edward Phill:	ips, Sr.		Brooksie	Gambri11		
er traums		19a. Informant's Name/Relationship (Type. Print) Emma Jean Phillips/spot	0.00	Mailing Address (Street				
Important: if item 27 is marked other than "n any Injury or other traumatic event, the Medi once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )	om State I	Disposition (Name of crematory or other place Cemetery			c. Location - City Hebron,	
mport ny Inj nce.		21. Signature of Funeral Service Licensee		22. Name and Addre	1			elmar, DE 19
sician edical		Immediate Calse (final disease or condition resulting in death)	to (or as a consequence of)	Failure				ONE YER-
	llner	Sequentially list conditions, if any, leading to immediate cause. First Underlying.	to (or as a consequence of)					7
burial-transit	al Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		):				7
burial-transit	al Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Use 2 Not 12 months?	to (or as a consequence of)	):			23d. Date of Month	delivery Day Year
signed by the attending physician and be detached for use as the burial-transit	by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No	to (or as a consequence of to (or as a consequence of outcome of pregnancy ve birth 2   Fetal death regnant at time of death nknown	):  3 ☐ Ectopic pregnanc 5 ☐ Other (specify)			Month	Day Year e to the cause of death?
Is been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	to (or as a consequence of to (or as a consequence of outcome of pregnancy ve birth 2   Fetal death regnant at time of death nknown	):  3 ☐ Ectopic pregnanc 5 ☐ Other (specify)		1 XYes  24a. Was an autopsy performe	Month  2 No 3 24b. Were prior deatl	Day Year e to the cause of death? Probably 4 Unknow e autopsy findings availab to completion of cause o
Is been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions contributing the conditions conditions contributing the conditions con	to (or as a consequence of to (or as a consequence of outcome of pregnancy ve birth 2   Fetal death regnant at time of death nknown	):  3 ☐ Ectopic pregnance 5 ☐ Other (specify) the underlying cause give	en in Part I.  26. Place of Death	1 XYes  24a. Was an autopsy performe 1 Yes 2	Month  2 No 3 24b. Were prior deatl	Day Year e to the cause of death? Probably 4 Unknow e autopsy findings availab to completion of cause o
Is been signed by the attending physicial should be detached for use as the burning the burning and the burning and the burning and the burning attention to the burning and t	To be Completed by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to the conditions conditions conditions condi	to (or as a consequence of the	3  Ectopic pregnand 5 Other (specify)	en in Part I.  26. Place of Death er: 4 \( \text{Nursing Hom} \)	1 Mayes  24a. Was an autopsy performe 1 □ Yes 2 C (Check only one) ne 5 March Residence	Month  2 No 3   24b. Were prior deatl 1   No 1   Cce 6 Other (5	Day Year  e to the cause of death?  ] Probably 4 □ Unknow  e autopsy findings availab to completion of cause of h? Yes 2 ☎No
Is been signed by the attending physician and 2 should be detached for use as the burial-transit	To be Completed by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing the conditions conditions contributing the conditions conditions conditions conditions contribut	to (or as a consequence of the	3	en in Part I.  26. Place of Death er: 4 \sum Nursing Hom ry at k? Yes 2 \sum No	1 X Yes  24a. Was an autopsy performe 1 Yes 2 (Check only one)  ne 5 X Resident 8d. Describe how	Month  cco use contribut  2 No 3  24b. Were prior deatl  No 1 No 1  cce 6 Other (so injury occurred)	Day Year  e to the cause of death?  ] Probably 4 □ Unknow  e autopsy findings availab to completion of cause of h?  Yes 2 ☎No
ral Director: After this certificate has been signed by the attending physician and lied in by the funeral director, page 2 should be detached for use as the burial-transit	To be Completed by Physician/Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	to (or as a consequence of the	3   Ectopic pregnand 5   Other (specify)   the underlying cause give t	26. Place of Death er: 4 \sum Nursing Horr y at k? Yes 2 \sum No	1 Mayes  24a. Was an autopsy performe 1 □ Yes 2 C (Check only one)  1 ■ 5 May Residence 1 Be continued to the cause of th	Month  2 No 3 24b. Were prior deatt 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Day Year  e to the cause of death?  ] Probably 4 □ Unknow  e autopsy findings availab to completion of cause o h? Yes 2 ☑No  Specify)  r Rural Route Number,  er as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] | State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23 Day 2010 Year Physician/ Ropshaw August 3:05 a.m. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 ፟፟፟ M 2 ☐ F **Funeral** Ohio Months Days Hours 07/05/1942 Director 223-62-2834 68 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | St. Mary's Leonardtown 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States 20650 22680 Cedar Lane Court, Apt. 1128 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Divorced Specify: Completed White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 6 <u>Mailing</u> Clerk Mail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maxine M. Edwards Fernando E. Ropshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16166 Dury Road, Ridge, MD 20680 Peter Ropshaw/Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State 4 Donation 5 Other (Specify) 08/25/2010 Charlotte Hall, MD Brinsfield-Echols Brinsfield Funeral Home, P.A. MD 20650 21. Signature Speral Sylvingson
Edward N. Brinstield, Jr. 22. Name and Address of Facility M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Aspiration Pneumonia Hours Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transi Years <u>Cerebral Palsy</u> that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown ☐ Yes 2 L ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 A N certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 5 Pending 1X Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital To the Hospital within 24 hours of To the Funeral I Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 RMe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajbinder S. Gill, 20650 M.D. 25500 Point Lookout Road, Leonardtown, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 25

egistrar's Signatur

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 19 2010 ear **7:30** а м Margaret Elizabeth Rill Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospice Dove House Carroll Westminster 8. Date of Birth (Month, Day, Year) Jan 31, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 X F Months Hours Mary land Director 213-38-5436 96 Usual Residence of Deceden 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at Director Westminster Maryland Carroll 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a 21157 USA 2550 Bird View Road 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò þ white 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa If Yes, Give 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ John Easton Clara Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 Chase Street, Westminster, MD 21157 Barbara D. Wardenfelt, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Sykesville, MD Memorial Park 8/23/2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1. Enter the disease, , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Kidney cancer years Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 ANo 9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death ed by the a 9 Linknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 X No this certificate 1 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific ripleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: 1 Yes 2 No ဂ္ ER/Outpatient 3 DOA hospice 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Funer completed file 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

Registrar DHMH 17 Rev 7/2009

State

15

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Howard G. Lanham, M.D. 215 Washington Heights Medical Center

MID

32. Registrar's Signature

29c. License number D17040

29d. Date signed (Month, Day, Year)

Westminster, MD 21157

August 20, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23aPt1,25 per me,8908,10/2010 Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OR Physician/ ΊοιΦ Anne Medical 4a. Facility Name (in not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical Center N/A 6, Sex 8. Date of Birth (Month, Day, Year) May 29, 1930 Social Security Number **Funeral** 9. Birthplace (State or Foreign 1 M 2 XF Mary Land **Director** 216-28-4368 80 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Carroll 1 Tes 2 X No Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7027 MacBeth Way 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Completed by ☐ Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) <u>Bookkeeper</u> MTS Financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Voll Marguerite Sir t. Page 1 and 2 should by thent of Health and Mer rant, If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward R. Ripper, Jr. Husband 7027 MacBeth Way Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important; If ite 5 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury 8/23/2010 Lakeview Mem Park Eldersburg, Maryland Signature of Funeral Service License 22. Name and Address of FacilitPritts Funeral Home & Chapel, PA 1 412 Washington Rd. Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the bunial-transit **Aortic Stenosis** that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Year Day sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 XYes Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. NJL 2010 completed cause of death (Item 23a) (Type, Print) Baltimore 21201

State Registrar 31. Date filed (Month, Day, Year)

**AUG 19** 

22 S Graun S

10-06026 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cherene Dawn Ruth State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1148 hrs Modical Examiner August 11, 2010 Cherene Dawn Ruth 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chester River Hospital Center Chestertown 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 05-23-1967 521-29-1151 43 Country) 1 M 2X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 V No 28a-f show MD Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Kent Chestertown 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21620 USA 212 Roundtop Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 Yes 3 Widowed 4 Divorced Give Year 1 Yes 2 X No specify: Specify: White ₽ 16a. Decedent's Usual Dccupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than the Medica Homemaker Own home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carol Allen Kinnecom Charles David Hughlett 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Roundtop Road Chestertown, MD 21620 John Ruth- Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Cremation 8/17/2010 Stevensville, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Fellows, Helfenbein & Newnam21. Signature of Funeral Service Ligenses 12 30 Speer Road Chestertown, MD 21620 Approximate Interval 23a, Part I, Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last : Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and led for use as the burial - transi sician/Medical 23a,pt.II,27,28a-f per me g907 9-10-10 vt X UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth Fetal death Month Day Year 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown 무 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Ovarian Carcinoma Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has death? ✓ Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 1 Natural 1 Yes 2 X No 5 Pending in by the f Director: 8-11-10 8:23am unknown 2 \_\_\_ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 212 Round Top Rd. Chestertown, Queen Anne's Md 21620 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide (Specify) residence To the Funeral Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State 31. Date filed (Mor 17 187, Y) and

Registrar

B

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32. Registrar's Signature

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 12, 2010

30. Name and address of person who completed cause of death (Item 23a)

eselle

DOME

Laron Locke MD.

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State of Maryla	and / Depa <i>Cer</i>	artment of F tificate of L	lealth and I Death	vlental Hygi R∈	ene g. No. 2010	0 27939
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	Medic Examin		4a. Facility Name (if not institution, give				Location of Death		19 201 4c. County of De	
			Atria Assisted Li 5. Social Security Number 6. S		s. last birthday)	Sali	Lsbury I If Under 24 Hrs.	Lo Debretorio	Wicom	
	Funeral Director		214-03-1475	□M2XF	94 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 18–16–19	rear) (	Birthplace (State or Foreign Country) Maryland
	and show 1 at	ē	Usual Residence of Decedent  10a. State  10b. County	10c.	City, Town or Loc	ation				10d. Inside City Limits
	Maryl. 28a-f otifiec	irect	MD Wicomi	co	Willard	s				1 🌠 Yes 2 ☐ No
	ith the 3a or t be n	ra D	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (	Country?
	eath w tems (	Funeral Director	36204 Old Ocean  11. Marital Status	12. Was Decedent Ever in	U.S. 13. V	as Decedent of Hi	874 spanic Origin? (Sp	ecify Yes or No-	USA 14. Race - An	nerican Indian.
36	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		Yes, specify Cuba ☐ Yes 2 🔀 No		Rican, etc.)	Black, Wh	nite, etc.
<u>-</u>	hours natura dical E	olete	15. Decedent's E		16a. Deced	ent's Usual Occupa	ation	. 1	6b. Kind of Busines	White s Industry
Maryland 21215-0036	s filed within 72 hour tal Hygiene. sd other than "natur event, the Medical	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	ind of work done d NOT use retired)	lunng most of work	ang		
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ylar	should be file n and Mental I <b>7 is marked o</b> raumatic eve	은	Ray	Α.	Denn	is	Lillie		К.	Dennis
Mar	12 shou alth and 27 is m r traum	#	19a. Informant's Name/Relationship (7)	,	15.1				ity or Town, State, 2	
	and Hear term		Crawford A. Rayno 20a. Method of Disposition	200	. Place of Dispos	ition (Name of			S. Maryla Oc. Location - City of	
Baltımore,	Page ment c tant: If		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		cemetery, crem ennis Co	atory or other place emetery		3-2010 V	Villards.	Maryland
Rail	permit. Page 1 Department of Important: If it any injury or conce.	ıij	21. Signature of June all Service License	ee Plack	, .	Name and Addres	s of Facility	Bounds Fu	neral Ho	me
			23a. Part 1. Enter the disease, or companions of the companion of the comp	cations that caused the de						land 21804 Approximate
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_	cate be executed physician and s the burial-transif	edical E	resulting in death) Last	Due to (or as a conse	equence of):					
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DOX 00	ith cert ittendir or use	ian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	etal death 3 🗌	Ectopic pregnancy	/		23d. Date of d	
, 0	the des y the a	Physician/N	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	of death 5 🗆	Other (specify)			Month	Day Year
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2	ne faw e has l	Completed						24a. Was an autopsy performe	prior to death?	
<u>.</u>	<b>hysician:</b> The lav nis certificate had I director, page 2		25. Was case referred to medical examiner?			26. Pla	ce of Death (Check	1 Yes 2 only one)	✓ No 1 L Ye	es 2 No
5	Physic this corral dire	욘	1  Yes 2 No	lospital: 1 ☐ Inpatient 2 1 28a. Date of injury	ER/Outpatient		4 U Nursing Ho			cify) Asst. Lvng
	nding ath. r: After re fune	icate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	28c. Injury work? M 1 1		28d. Describe how	injury occurred	
2 2	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
2	nspital hours and meral C	- 1	29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge, death or	cured at the time,	date and place, an	d due to the cause	(s) and manner as s	tated.
	the Ho hin 24 the Fu nplete	Medical	only one) 3 Certifying Nurs	e Practioner: To the best of	non and/or investig my knowledge, de	gation, in my opinior eath occurred at the	n, death occurred at time, date and plac	the time, date and pe, and due to the ca	place, and due to the use(s) and manner a	cause(s) and manner stated. s stated.
	o d ¥i o		29b. Signature and title of certifier	1111 111		29c. License	number	290	d. Date signed (Mon	th, Day, Year)
,	61		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type, Pri	nt)	2019		9/1/10	M A A
	AV.		29b. Signature and title of certifier    Ualum	noug MA,	106 lu	111000	14- 50	415 54	1/s/pury	7/864
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	Marylan	•				and M	ental Hy	giene	Э	
			State Registrar			Cer	tificate	of De	eath			Reg. No	2010	27940
	Physicia	ın/	1. Decedent's Name (First, Middle		a1						<ol><li>Date of De Month</li></ol>		y, 2010	3. Time of Death
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,	Examir	er	Calvert Count		ŕ		4b. City, To		Fred		·k	40	Calver	
- 14	Funeral		5. Social Security Number		7. Age (In yrs. Ia	ast birthday)	If Under 1	Year	If Under 2	4 Hrs.	8. Date of Bir		0.00	halana (Ctata au Faurius
-militire of	Director	į.	214-28-3847	1 □ M 2 🖾 F	81	Yrs.	Months [	Days	Hours	Min.	07/31/	1929	9 Col	Maryland
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	ryland -f sh ied a	ctol		,	10c. City	y, Town or Lo								10d. Inside City Limits
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Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Hamportant: If ite any injury or ot once.		21. Signature of Funeral Service	Licensee Ht	>									
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-	Physician.	i a	Immediate Cause (Final disease or condition	_ a	Sepsis	Sy	ndo	me	/					Onset and Death
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Division of Vital Records,	r Atte ter de recto	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	mined 28e. Place o	of Injury - At ho	me, farm, stre	et, factory, of	ffice		2	8f. Location (S		d Number or Run	al Route Number,
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	Hosp 14 hou Funer ted fill	Medical	(Check 2 L Medical	g Physician: To the bes Examiner: On the basis	of examination	n and/or invest	igation, in my	opinion,	death occ	curred at t	he time, date a	ind place	, and due to the c	ause(s) and manner stated
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	F ≥ F 8		Described and side of contine	11	7		290, LI		)	2 17	7		te signed (Month,	
			30. Name and address of person	who complete called	of death (Item	23a) (Tupe B	rint)	<u> </u>	) .	716	7		~ U )~ !	
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DHMH 17 Rev 7/2009

Registrar

AUG 2 4 2010

10-06262 Jeremy Scott Shaf		Type or Print i State of Maryla							_	010	0701
	1- For State Registrar	otato or maryn		tificate of		na mon	.c.r r ry s		Reg. No.	UIU	2794
	1. Decedent's Name (First,	Middle,Last)					2.	Date of De	ath	/ear	3. Time of Death
Medical Examine	Jeremy 4a. Facility Name (if not ins	Scott	Shafer	I	b. City, Town,	or Location o		August 1	9, 2010	ty of Deat	1145 hrs
	28966 Shannon C		umber)	"	Mechanic		Death		St. Ma	•	41
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. la:	st birthday)	If Under 1 Ye	ear If Under	r 24Hrs.	8. Date of B	irth(MM/DD/YY		rthplace (State or
Director	298-60-6095	1[X]M 2[F	33	Yrs.	Months Da	ays Hours	Min.	07/1	8/1977	Forei	gn Duntry) Ohio
×	Usual Residence of Decede		Lie- en-	Town or Location							Table 11 on 11 o
ow an	10a. State 10b. Co	St. Mary's		chanics							10d. Inside City Limits  1 Yes 2 X No
ryland rayland rates the core	10e. Street and Number	ot. Mary 5	Het	lianies	10f. Zip Code				10g. Citizen of	What Cou	
the Maryland a or 28a-f sh iffed at once Director	28966 Shani	non Court				659			US		, .
r death with the Maryland or items 23a or 28a-f show any must be notified at once. Funeral Director			cedent Ever in U.S		Decedent of I						rican Indian, Black,
or death with	1 Never Married 2	1 X Yes	2 No	If Ye	s, specify Cub	an, Mexican,	Puerto Ri	can, etc.)	W	hite, etc.	
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5-0036 ed within 72 hour lygiene. other than "natt the Medical Exal Completed	Elementary/Secondary (0				st of working li				16b. Kind of	Business	industry
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2121 ald be fi Mental ] marked event,				10h Mailing	Address (Ctr		orah	Ly	nn V mber, City or To	ance	Zio Codo)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Memtal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Kelly Lynn								sville,		
e, N I and Health item	20a. Method of Disposition			lace of Disposit	ion (Name of c			ate			Town, State
MOF Pages ent of int: If	1 X Burial 2 Crem 4 Donation 5 Oth		om State	yland V		۔ ا	08/30	1/2010	Chelt	onhar	n MD
altil	21 Signature of Funeral Se					ss of Facility	0075	Funera	al Home	Р	20622
	Edward N. Bi		r. M0005	2 30	1195 Th	ree No	tch !	Rd., (	Charlot	te Ha	all, MD
Physician /Medical	23a. Part I. Enter the diseas failure. List only one c	ause on each line.			mode of dying	g, such as ca	rdiac or re	spiratory an	rest, shock, or l	neart	Approximate Interva Between Onset and
Examiner	Immediate Cause (Final dis or condition resulting in dea	11.5	unshot Wound consequence of):								Death .
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Box 68760, e death cert foute be ex- the attending physician ed for use as the burial. hysician/Medic.	IF FEMALE: 23b. Was decedent pregnan past 12 months?	t in the 23c. If yes, to	outcome of pregna pirth		I death 3	Ectopic	pregnancy	,	23d. Date Month		y Day Year
OX 6 ath cel	1 Yes 2 No 9	Unknown	ant at time of deat	th 5 Othe	er (Specify)						
o. O. Bothat the described by the added of the detached for the aby the added for the	Part II. Other significant co	9	o death but not res	sulting in the un	derlying cause	given in Parl	t I.	23e. Did to	obacco use cor	ntribute to	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach brification: To Be Completed by Pl	î			•	. •			1 Ye	s 2 🗸 No	3 Prol	pably 4 Unknown
Records,  The law requires ficate has been sig								24a. Was			topsy findings available completion of cause of
eco he law te has uge 2 s		<del></del>						perfo	ormed? 2✔No	death?	
Vital Rechysician: The Lithis certificate Lithis director, page	25. Was case referred to me	edical			26.Plac	ce of Death (C	check only				
F Vita Physicia or this ce	1 <b>✓</b> Yes 2 No	Hospital: 1 1		R/Outpatient			Nursing H		Residence 6		. Scene
n of ding Pl		28a. Date (Month Pending FOUND	Day Year)	28b. Time of Inji FOUND:		ury at Work? Yes 2 ✔ N	[Qu	d. Describe bject sho	how injury occu ot self	ırred	
Division ospital or Attending tours after death.  neral Director: After filled in by the functions of the function of the func	2 Accident	Investigation Aug 19,	2010 - At hom	1142 hrs				f Location (	Street and Num	her or Pu	ral Route Number, City
Divi	3 Suicide 6 Homicide	Could not be	Single Famil		ractory, office	bullaling, etc.		or Town, S			
Hospi 24 hou Funer rtely fil		ng Physician: To the bes			d at the time, o	date and plac					
Division of Vital Records, P.O. Box 68750,  To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.  Medical Certification: To Be Completed by Physician/Medic	one) 2 Medical	Examiner: On the basis of and manner s	of examination and								
Ž	29b. Signature and title of ce	ertifier				se number					nth, Day, Year)
	N)-M	/ L			0.0	.M.E.			August 20	J, 2010	
ne	30. Name and address of pe Donna M. Vincenti		se of death (Item 2 Medical Exami	,	Penn Stree	t. Baltimor	e. MD 2	21201			
State			gistrar's Signature		·	.,	J, 100 2	- 1 - 0 1			
Registrar			Z.	4 1	, Kel						

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Ам Rosetta Virginia Sutphin August 2010 6:58 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospice House Callaway 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months Days Hours Min (Month, Day, Year) Director 220-40-5890 90 Yrs. ebruary 20. Virginia 1920 Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Charles Bryantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 20617 6966 Leonardtown Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ ö 1 Never Married 2 Married 2 🛛 No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည traumatic Thomas William Bessie Ada Goad and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Gary Wayne Sutphin / Son</u> P.O. Box 156, Bryantown, MD 20617 or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 30,2010 Hollywood, Maryland Nazarene Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Michae P.O. Box 270, Leonardtown, MD 20650 23a. Part Lenter the disease, or compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Year Dav Yes 2 No Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 2 X N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State within 24 hours a Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 40155751 25 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 15 Rme 40900 Merchants Lane, Ste. 205, Leonardtown, MD 20650 Jennifer M. Schmidt, D.O. 31. Date filed (Month, Day, Year) 32. Reg State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 27943 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 18 Day 2010 ear George Earl Stull, Jr. 7:38 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Citizens Care & Rehabilitation Center Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 29, Year 924 219-12-2297 1 XX M 2 □ F 86 Mary Tand Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 160 A Willoedale Drive #201 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2XX No Specify: White If Yes, Give Year or Dates. and 2 should be filed within 72 hours aft Health and Mental Hygiene. tem 27 is marked other than "natural", 3 Widowed 4 Divorced WWIT Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Drywall Installer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Covell George Earl Stull, Sr. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201, Frederick, 160-A Willowdale Drive, Apt. permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr If item 27 Betty M. Stull / Wife 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Resthaven Crematory Frederick, Maryland 2010 4 Donation 21. Signature of Funeral Service Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the disease, or co shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death s been signed by the s 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 1 🗌 Yes 2 🔲 No Yes 2 No the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certific mpleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No Hospital ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a
To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

State Registrar

3 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

801

32. Registrar's Signature

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type or P			Indelible In partment of I			-		_	<b>).</b>	
	•	for State Registrar			, , , , , , , , , , , , , , , , , , ,		ertificate of				_	2010	279	44
Physicia		1. Decedent's Name Elizabeth		<sup>Last)</sup> en Sweeney	,		+			2. Date of De August		<sup>0</sup> ay 2010 <sup>Year</sup>	3. Time of D	
Medic Examin		, ,		give street and numbe	r)		4b. City, Town, c		of Death		4	c. County of Dea		
Funeral		8816 Dove 5. Social Security No.		6. Sex 7.	Age (In yrs. Ia	ast birthday		If Unde	er 24 Hrs.	8. Date of Bi	rth	Charles 9.8	irthplace (State or I	Fo <i>reig</i> n
Director		230-74-22 Usual Residence of		1 □ M 2 🐺	58	Yrs.	Months Days	Hours	Min.	May 8	ay, Your	952 VI	rginia	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment if firem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State	10b. County			y, Town or I							10d. Inside City	
the Mar or 28a e notifi	Funeral Director	Maryland 10e. Street and Nun	Charl	.es	_  Be	el Alt	10f. Zip Code				10g. C	Citizen of What C	1 🗆 Yes 2	X X NO
n with	neral	8816 Dove	Drive				20611					J.S.A.		
er deat or iten niner r	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Marri</li></ul>	ied 2 🛭 Marri	12. Was Deceder Armed Force 1 Yes 2	s?	3. 13	I. Was Decedent of F If Yes, specify Cub	an, Mexica	an, Puerto	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh		
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85		30. Name and addre	ess of person w	he completed cause of	f death (Item	23a) (Type		10	Pla	to	~	10 L	0646	
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	Examin	er					Leona		Location of	or Death		- 1	c. County of		-	
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Baltimore,	Page 1 nent of l ant: If it		1 X Burial 2 ☐ Cremation 3		ate C	emetery, cren	natory or ot	ther place			Date			•		
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			23a. Part 1. Enter the disease, or c	omplications that cau	sed the deat								i COWII,		Approxim	
	Physician/		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	line.	RD									Interval B	
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9	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical		d												
687	rtifica ing pl	Me	IF FEMALE;			0.70 100										
9 ×	ath certifica attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		th 2 🗆 Feta	aldeath 3			у			i	23d. Date		ery Day	Year
Вох	the dear by the at tached for	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4 ☐ Pregnar 9 ☐ Unknow		death 5∟	Other (sp	ecify)					WOIT	'	Day	Teal
P.O.	at the d by letacl		Part II. Other significant condition	s contributing to deat	h but not res	ulting in the u	nderlying c	ause give	en in Part I	l.	23e. Did t	obacco	use contribu	ute to th	ne cause of	f death?
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	To the Hospital or Attend within 24 hours after deati To the Funeral Director: completed filled in by the	Medical		Physician: To the best aminer: On the basis of												nanner stated.
	the H hin 24 the F mplet	Me	only one) 3 $\square$ Certifying N	lurse Practioner: To t			death occur	red at the	time, date			ne cause	(s) and mann	er as sta	ated.	
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en	re		30. Name and address of person wi							1	4	<b>m</b>	20650			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene o Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Elliott Williams 2010 0842 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital at Easton Talbot raston Memonal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) **Funeral** 216.82- 4798 1**№** 2□ F Director nary lance 2010 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Completed by Funeral Director 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2/61 Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or ite other traumatic event, Inc. W. Iten Exam. 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 🔼 No Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Way Cambridge MD 216B Williams 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' permit. Pages Department of Important: If its any injury or o o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 8/20/2010 Cambridge 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 510 Washington anelle MD Cambridge, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 min disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Ye ar Day 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performe 2. 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No

27. Manner of Deat
1 Natural 5 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ours after death.

leral Director: A
filled in by the fu

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8-17-10 son who completed cause of death (Item 23a) (Type, Print) Easton, MD 605 MD Dutchman's 31. Date filed (Month, Day, 3. Registrar's Signature State AUG 20 Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 **Physician** 1705 M August 2010 Victoria Lake Waters /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester General Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) Months 1 □ M 2 🗓 F Director 214-07-8829 95 Maryland July 25, 1915 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be required Director 1 X Yes 2 □ No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 913 Maces Lane Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, filed within 72 hours after of Hygiene. Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ₩ Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Worker Board of Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumeric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Monroe F. 2 Lake,Sr. Leomia E. Dennard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benito D. Lake, Sr./Son 2301 Church Creek Road Cambridge, Maryland 21613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bazzel Cemetery 8-21-10 Bucktown, Maryland 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility 812 Hubbard Street 12 dare Boardley Funeral Home Cambridge, Maryland 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse Examiner Sequentially list conditions, if any, and its Lindward cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ed by the detached 1 ☐ Yes 2 No 9 Unknown 9 ☐ Unknowr signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has be irector, page 2 st 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Yes 1 Papatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural n 24 hours after death.

Reference Aureral Director: A pletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 hor To the Fune (Check only 29b. Signature and title of certi 29c. License number 29d. Daty signed (Month, Day, Year)

State Registrar verne

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

vervini

Year)

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

## NULLIAM RICHARD WATERMAN  WILLIAM RICHARD WATERMAN  ## AUGUST 22, 20TO  ## AUGUST 2		Registrar	erincale or Dealir	Reg. No.
South Security Victories  20 ONDERSET STREET  10 South Security Victories  22 O 94 40 59  10 South Security Victories  10 South Secu				
220 - 94 - 40 59   XX   2   F   46   Vr.   Months   Open   More			LA PLATA	CHARLES
Month   Charles   Market   M		220-94-4059 1XX 20F 46 Yr	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) NEW HAMPSHIRE
23a. Part I. Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List orly one cause on each line.  Approximate shock, or heart failure. List orly one cause on each line.  Approximate shock, or heart failure. List orly one cause on each line.  Approximate shock, or heart failure. List orly one cause on each line.  Approximate shock, or heart failure. List orly one cause on each line.  Approximate shock, or heart failure. List orly one cause on each line.  Approximate shock, or heart failure. List orly one cause on each line.  Approximate shock, or heart failure. List orly one cause on each line.  Approximate shock, or heart failure. List orly one cause or respiratory arrest. Increment of Death of Cause for Injury and the past 12 months?  1	or	10a. State 10b. County 10c. City, Town of		
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Pring resulting in death)  1	ompleted	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of working to NOT use retired)	BRANDYWINE
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List orly one cause on each line.  1 Part II. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, considering the shock, or heart failure. List orly one cause on each line.  2 Sequentially list conditions cause. On each of the cause of the cause of the cause of the cause. Enter flusterlying cause of death?  2 Set via cause referred to medical state of death but not resulting in the underlying cause given in Part I.  2 Set via cause referred to medical state of death cause. It is not death cause. It is not death cause of death?  2 Set via cause referred to medical state of death cause. It is not death cause. It i	To Be C			• • • • • • • • • • • • • • • • • • • •
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23e, Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on seach line.    23e, Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced cause. (Pinal Part		1 ☐ Burial 2 XX emation 3 ☐ Removal from State RIVERD		23, DIVIDDALD ND
Sequentially list conditions		La levance	TERRENCE L. JOHNS 4433 WHITE PLAINS	SON FUNERAL SERVICE, PA S LN., WHITE PLAINS, MD
In the past 12 months?   1	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  a.  Due to (or as a consequence of Disease or injury that initiated events)	ebesity	Onset and Death
1   Yes   2   Mo   3   Probably   4   Unknown	- 6	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  23c. If yes, outcome pr pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death		
25. Was case referred to medical examiner?    Natural   S   Pending investigation   S	þ	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.	
26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  3 Suicide  4 Homicide  28c. Place of injury - At home, farm, street, factory, office  28d. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	complete			autopsy prior to completion of cause of death?
27. Manner of Death   1 Natural   2 Natural   5   Pending investigation   6   Could not be determined   28e. Place of injury   28e. Place of injury   At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)    29a. Certifier (Check only one)   2 Nedical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29c. License number   29d. Date signed (Month, Day, Year)   29d. Date signed (Month, Day, Year)	Be	examiner?	Other	
29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  8 - 23 - Color		27. Manner of Death 11⊠ Natural 5 □ Pending (Month, Day Year) Inj	ne of 28c. Injury at 28c. Work?	
29a. Certifier  (Check only one)  Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	ertifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm	a, street, factory, office	
Yahia M. Tayouni MD 0050883 8-23-2010	edical (	(Check only 2 Medical Examiner: On the basis of examination and		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Schin M. Tayour Mo 11655 W. MS. p 16 (aPlata MD 26646	M	Yahia M. Tayouri M	D 0050883	8-23-2010
	5	30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	Caplata MD 20646
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 4 2010 Century D. August 1		31. Date filed (Month, Day, Year)  AUG 2 4 2010  Section 1.	arke	

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			1. Decedent's Name	(First, Middle	, Last)							2. Date of Dea			3. Time of Death	
	Physicia /Medic		Helen		Lou	ıise			We	stfa	11	August	19	9, 2010	8:02A M	
3.6	Examin		4a. Facility Name (If		_				4b. City,	Town, or	Location of Death	1	40	c. County of Deat	h	
and the					Nursing					Pla		0.04.40		Char		
	Funeral Director		5. Social Security Nu 314-12-4		6. Sex 1 □ M 2 🛣 F	7. Age	(In yrs. la	ast birthday) Yrs.	If Under Months	Days	If Under 24 Hrs. Hours Min.	(Month, Da	ıy, Year,	9. Birt	thplace (State or Foreign buntry)	
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	s 23a	Funeral	509 Dog	wood Co							646			USA		
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920	urs aff	5	3 X Widowed 4		If Yes, G	ive			1 □Yes 2	2 <b>∏X</b> No	Specify:			Specify: W	hite	
2-0	filed within 72 hours after death with the Maryland Hygiene Hygiene Hydrall, or items 23a or 28a-f show ther than "natural", or items 23a or 28a-f show ant, the Medical Evaring must be notified a	Completed	/Snaci	15. Decedent	s Education t grade completed	`		16a. Dece	dent's Usua	Occupa	ation during most of work	king	16b. h	Kind of Business/	Industry	
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anc	i be fi intal h ed ot ed ot	Be	Benjamin		.asi)							et Wilso	n, Maiden Surname)			
<u> </u>	should bd Me mark matic	၉	19a. Informant's Na		in (Type, Print)			19b. Maili	na Address	(Street a	and Number or Ru			or Town, State, 2	Zip Code)	
Trudy Bramel1/Daughter 509 Dogwood Court, La Plata, MD 20646																
The property of the property o												Town, State				
<u>ii</u>	10a. State   10b. County   10c. City, Town or Location   10c. City   1											ington,	Virginia			
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ecc	e law re has be je 2 sho	plei										24a. Was		24b. Were au	utopsy findings available completion of cause of	
= E	Attending Physician: The law requires that the death cer stretch. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use	Completed										perfo 1 □Yes	rmed? 2 X N	death? o 1 □Yes	2 □ No	
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DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amended item#8, WCHD, 08.23.10 Certificate of Death SU 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Thelma Elizabeth Williams August 16, 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Wicomico 706 Taft Court Apt. A Salisbury 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 1 F Months Days Hours Min 86 May 24, 222-12-4532 1924 Delaware Usual Residence of Decedent May 20, 1924 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 Taft Court Apt. A 21804 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 X Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) waitress restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Brittingham Hetti Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin A. Jones (grandson) 108 Centenary Drive Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stephens CemeteryAug. 19, 2010 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 13 East Grove Street Short Funeral Home Delmar, DE 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ZEVERHL YR Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease underlying that initiated events resulting in death) Last

24a. Was an autopsy performed? Ves 2 2 No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Yes 2 □ No 27. Manner of Death

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1X Natural

2 ☐ Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print)

303 SNOW St.

State Registrar

ORG THY 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Deborah Grace York August 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3325 Sutton Court Manchester Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Months Hours Director 218-60-2786 Tune 28,1953 Maryland Usual Residence of Decedent or 28a-f show e notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland Carroll Manchester 1 X Yes 2 ☐ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 3325 Sutton Court 21102 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 XMarried 72 hours after Maryland 21215-0036 ental Hygiene. ked other than "natural", o c event, the Medical Exam If Yes, Give Year or Dates. 1 Yes 2 XNo Specify: white Specify: 3 - Widowed 4 - Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home rould be filed with nd Mental Hygien marked other ti 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev George Blake Bernice Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Heagerty / daughter 106 Falabella Drive Stephens City, VA 22655 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Carroll Cremation 4 ☐ Donation 5 ☐ Other (Specify) Aug 18, 2010 Hampstead, Maryland . Signature of Funeral Service Lice 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street HAmpstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): burialthe attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? Hospital: Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b, Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 156 3 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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32. Registrar's Signature

Mancheder Rd Manches

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ len AMonth 52M Medical Facility Name (if not institution **Examiner** Town, or Location of Death 4c. County of Death rede If Under Year If Under 24 Hrs. 8. Date of Birth **Funeral** Security Number . Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 D F 3 Months Days Hours Min. Director Yrs and d Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No Ums 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 No 1 ☐ Yes 2 MANO Specify. 3 - Widowed 4 - Divorced Specify: Completed 1) /ac 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden 2 ae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City ohn risban 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign un of Funeral Sérvice License 29. Name and Add 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ boli 5 m disease or condition resulting in death) non Medical Due to (or as a consequence of): **Examiner** eb 4 Sequentially list conditions, Examine cause (Disease or linjury Due to (or as a consequence or) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atter page 2 should be detached for Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 🗌 No 1 🗌 Yes Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Tes 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending Investigation 1 ☐ Yes 2 ☐ No Director: Suicide 6 🗌 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Detail Hydrian Processor Hy Nineegy, death occurred at the time, date and place, and due to the cause(s) and miner as stated.

2 Detailing Nurse Processor Hydrian and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Detailing Nurse Processor Hydrian and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1060396 08 1 7

Registrar

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 3:00 AM Thomas 2010 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 8810 Walther Blvd. Apt. Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Months | April 22, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** . 1933 1**X**XM 2□ F 213-30-9310 77 Director PA. Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits Director Baltimore County 1 ☐Yes 2X No Maryland | Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 2217 21234 USA 8810 Walther Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X□Yes 2□No If Yes, Give Year or Dates KOrean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2X XMarried 21215-0036 1 ☐ Yes 2√☐ No White ð Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Martin Marietta Elementary/Secondary (0-12) College (1-4or 5+) Programer Corp. N/A 12 yrs. Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Wilbur Axon Pearl Trout ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Walther Blvd. Apt. 2217 Balto., Md. 21234 Louisa E. Axon (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Gardens of Faith 9-9-2010 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Signature of Funeral Service Licensee E. 3 assakn 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cuenorsina dh disease or condition resulting in death) /Medical Due to (or as a sequence of Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine death certificate be executed and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 - No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician, within 24 hours after death.

To the Funeral Director, After this certifica director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Tyes 2 → No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 Accident 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated. in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of 29c. Li 29d. Date signed (Month, Day, Year) rson who completed cause (death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 253 AM September Sharon Anderson 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balt. Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months Davs Hours Min. March 10,1953 Country) Maryland 57 Director 214-62-2390 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director or than "natural", or items 23a or 28a-f si the Medical Examiner must be notified 1 Yes 2 No Pasadena Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 USA 5131 Mountain Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black. White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Insurance Insurance Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Thompson Anita π. Ε. Bernard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Μ. Anderson - spouse Mountain Rd., Pasadena, MD 21122 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Sept. 7 Metro Crematory, Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, Pasadena, MD 21122 3111 Mountain Rd, 23a. Part 1. Enter the disease, or complic shock, or heart failule. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Physician/ 100 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autops death? 1 Yes Yes the Hospital or Attending Physician: 25. Was case referred to medica æ 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after deat To the Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 0065208 bleted cause of (Item 23a) (Type, Date filed (Month, Day, 32. Registrar's Signature State Registrar

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	Physicia Medic			lerson							2. Date of De	path Da	ay Year	3. Time of Death 8:01 AM
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	Funeral		5. Social Security Number 6. Se		e (In yrs. la	ast birthday)		r 1 Year Days	If Under Hours		8. Date of Bir (Month, Da		9. Bi	irthplace (State or Foreign
	Director		220-22-6690 Usual Residence of Decedent	□м ЖП ғ	85	Yrs.	Months	Days	Hours	IVIIII.		O	25	MD
	land show dat	tor	10a. State 10b. County		10c. City	y, Town or Loc	ation							10d. Inside City Limits
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	eath refers	٦	1637 West Lexin 11. Marital Status	12. Was Decedent E			Vas Dece	dent of His	panic Ori	rigin? (Spec	cify Yes or No-	-T	U . S . A	
36	after de ", or it	þ	1 Never Married 2 Married	Armed Forces?  1  Yes 2  If Yes, Give	No			cify Cuban 2 <b>X</b> No		n, Puerto F	Rican, etc.)		Black, Whi	
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Baltimore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service License	Rimpso	~	Ma	rch	F/H	Wes	st	Do 144		- Ma	21215
			23a. Part 1 Enter the disease, or comp shock or heart failure. List only or	lications that aused	the death								e, Md	Approximate
Z	Physician/		Immediat ause (Final disease or condition	Septi		Thoch	c							Interval Between Onset and Death
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89	certifi ending use a	Z V	230. Was decedent pregnant	23c. If yes, outcome o			Catania					-	23d. Date of de	elivery
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Division of Vital Records,	or Atte after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc.			et, factor	, office		2	8f. Location (S City or Tow			ıral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  within 24 hours after death.  completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examin	cian: To the best of rer: On the basis of ex	ny knowle	edge, death of	ccured at	the time, o	date and a	place, and	due to the car	use(s) ar	nd manner as st	ated. cause(s) and manner stated.
	Fo the within 2 Fo the comple		only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the b	est of my	knowledge, de	eath occu	red at the t License r	time, date	e and place	, and due to the	e cause(s	s) and manner as te signed (Mont	stated.
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	2		30. Name and address of person who co	2000	W.	Balt	int)	e S	4.,	Bal	Himor	e,	MD	21223
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Antkowiak Bernard 5:30 PM 2010 Medical September 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore 1637 Joplin Street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1**∑** M 2 □ F Months Hours Mary Land Director 81 <u> 220-20-3855</u> Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 21224 1637 Joplin Street USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important; If item 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Foreman Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Choragiewicz Jacob Antkowiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1637 Joplin Street, Baltimore, Maryland 21224 Helen Antkowiak wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State September Holy Rosary Cemetery Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 8, 2010 21. Signature of Fundal Service Licensee Funeral Home Of Dundalk.P.A. 7110 Sollers Point Road, Dundalk,MD. 21222 23a. Part 1. Enter the disease, in complications that caused the de shock, or heart failure. List of ly one cause on each line. Immediate Cause (Final Ohset and Death Physician/ disease or condition Medical resulting in death) Examiner Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iin/Jury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year Tyes 2 □ No signed by the a 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 X No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 → Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 2 Accident 5 Pending injury s after death. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours 29a, Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

DHMH 17 Rev 7/2009

Registrar

State

Newland

3515

who completed cause of death (Item 23a) (Type, Print)

M.D

chwartz

2010

Sept 8, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05: 24 AM 00 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number **Examiner** ledecal nwe 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Age (In vrs. last birthday) If Under Funeral 10-20-1935 Days Months Min Country) 1 M 2XX MD 213-32-4857 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Baltimore MD na 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number USA Funeral 751 W. Saratoga Street 21201 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify Black Specify. "natural", 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natu ury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Keswick N/H Supervisor 9th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda Thomas Leon Dunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1713 E. Baltimore Street Apt 2 Balto, Jackie Burrell-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If its any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-8-2010 Greenmount Balto, MD Signature of Fundal Service Licensee 22. Name and Address of Facility March East F/H North Avenue Balto, MD 21202 1101 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a g Unknown g 🗌 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ᅆ 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: injury Natural Accident 5 Pending 2 🗀 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ 29c. License number 29b. Signature and title of certifier 6399 1010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persor

DHMH 17 Rev 7/2009

Registrar

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31. Date filed (Month, Day, Year)

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301

32. Registrar's Signature

10-06500	_	Please Type of							gibl	e.	
Jennifer Christin		runkhorst State  1- For State	of Maryland	•	rtment of <i>tificate</i> o <i>f</i>		nd Menta	l Hygiene		2010	27958
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Las	it)	Cer		Dealii		2. Date of Dea	Reg. No. ath		3. Time of Death
Medical Exami		Jennifer Christin		rst				Month August 28	Day 8, 201	Year 10	1303 hrs
		4a. Facility Name (if not institution, giv			4	•	or Location of D	eath		c. County of Deat	h
5		Upper Chesapeake Medic  5. Social Security Number 6. Se		e (In ure Io	ist birthday)	Bel Air	ear If Under 2	4Hrs 8 Date of Bi		Harford	rthniana (State or
Funeral Director			M 2XF	25	Yrs.	7	ys Hours	Min. 06-10-			rthplace (State or gn Duntry) Mass.
		Usual Residence of Decedent						. 100 10			,, 22000
w any		10a. State 10b. County MD Harfe	a m d		Town or Location	n					10d, Inside City Limits  1 Yes 2 No
yland n-f sho	ţċ	MD Harfo	JI U	Бе	T AII	10f. Zip Code		1.	10a Cit	tizen of What Cou	
vith the Maryland 8 23a or 28a-f show a 8 notified at once.	Director	1003 Saddleback N	Wav			2101	4	İ	rog. Oil	USA	
with t ns 23a be not		11. Marital Status	12. Was Decedent			Decedent of H	lispanic Origin?	(Specify Yes or No	0-	14. Race - Amer	ican Indian, Black,
r death or iter	Funeral	1 X Never Married 2 Married	1 Yes 2	X No		(37)		uerto Rican, etc.)		White, etc.	
rs afte ura!",	þ	Widowed 4 Divorced  15. Decedent's Education (Specify or	If Yes, Give Year or Dates:	pleted)	16a. Decedent		lo specify: ation (Give kind	of work done	16h	Specify: Whi	
72 hou n "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or				e. DO NOT use		100.	Tana or Baomoos	madetty
vithin ene.	dm		1		Never V	Vorked				n/a	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)  John R. Brunkhors						lame (First, Middle, $y \; C. \; 01se$		Surname)	
212 vuld be Mentz mark c even	To Be	19a. Informant's Name/Relationship (T			19b. Mailing	Address (Stre		or Rural Route Nur		City or Town, State	e, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fish injury or other traumatic event, the Medical Examiner must be notified at once		Shirley C. Brunkh	orst (Moth				-	Bel Air			
or Hea of Hea If iter		20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from Sta	ate cr	lace of Disposit rematory or other	er place)		Date		Location - City or	
Baltimore, permit. Pages 1 at Department of Her Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licen		Вау	view Ci		-	-02-2010		Baltimore	
Bal permi Depar Impo injur		James Commental Service Licent	See		722. Na	• 610 W	Sc. MacPh	himunek E ail Rd Be	Tune 114i	ral Home	e of BelAir
Physician		23a. Part I. Enter the disease, or com- failure. List only one cause on ea		the death.							Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a.	Diabetic			s					Death
*		h	Due to (or as a conse	equence of)							
·	<u>le</u>	cause. Enter Underlying Cause	Due to (or as a conse	quence of)	:						
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ox 68760, ant certificate be ex- attending physician for use as the burial.	edic	X UNPENDED X	23a,27,			10.4/10	TT		Loo	d Data of talling	
S876 rrificat ling ph		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom		2 Feta	I death 3	Ectopic pre	egnancy	230	d. Date of deliver Month	y Day Year
Box 68760, e death certificate be the attending physic ed for use as the burned for use	/sici	1 Yes 2 No 9 V Unknown	4 Pregnant at	time of dea	th 5 Oth	er (Specify)					
		Part II. Other significant conditions	<u> </u>	but not res	sulting in the un	derlying cause	given in Part I.	23e. Did to	obacco	use contribute to	the cause of death?
ires that th	ed by							1 Yes	s 2 🗸	No 3 Prol	pably 4 Unknown
cords, law requir has been s	plet							24a. Was autop	sy	prior to	topsy findings available completion of cause of
	Completed							1 ✓ Yes	rmed? 2 N	death?	es 2 No
Vital sysician: ysician: his certif director,	a	25. Was case referred to medical examiner?	ospital: 1 Inpatie	nt 2 🗸 E	ER/Outpatient		Other		Reside	ence 6 Other	~
of Viiing Physical After this	읽	1 1 Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,Yo	ry :	28b. Time of Inj		ury at Work?	28d. Describe			
ttendii death.	atio	1 X Natural 5 Pending 2 Accident Investigation				1	Yes 2 No				
Division of Vital Records, ospital or Attending Physician: The law require hours after death, nerral Director: After this certificate has been siy filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined		ury - At hor	ne, farm, street	factory, office	building, etc.	28f. Location (S or Town, S		and Number or Ru	ral Route Number, City
D : Hospital 24 hours : Funeral etely filled		29a Certifier	an: To the best of my	knowledge	e. death occurre	d at the time, o	late and place.	and due to the caus	se(s) an	nd manner as stat	ed.
Division of Vital Division of Vital Of Utal Of Utal Of the Hospital or Attending Physician Within 24 hours after death.  To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	10.100.10	On the basis of exame and manner stated.								
[ > [ 3	ΣÍ	29b. Signature and title of certifier				29c, Licen			1	Date signed (Mo	nth, Day, Year)
		Mayore the	Shill	ooth /ltc 2	220		.M.E.		Aug	ust 29, 2010	
Ø V		<ol> <li>Name and address of person who of Margarita Korell MD. As</li> </ol>	sistant Medical	,	•	nn Street, E	Baltimore, M	ID 21201			70
		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1 1	4.1					
Regist	rar	SEP 0 8 20	11 Ckner	W/	9. AT 61	Kel					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. 30 per dvr g90/9-8-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 9<sup>Month</sup> Physician/ 5 Day 2018 8:52a<sub>M</sub> Bailey Janlee Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George Laurel Regional Hospital Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6 Sev 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Days Hours 181-42-5169 1 6 73 / 5 0 ear) Country Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Prince Georges MD Bowie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16010 Excalibur Road 20716 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. African SpecifAmerican 1X Never Married 2 ☐ Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry / Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public Education should be filed with and Mental Hygien is marked other th Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alma Stella Walker ပ James Omar Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $4000~{ t Gypsy Lane, Phil.,PA}~{ t (Unit 534)}$ permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Wanda Bailey-Green 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pleasantvilk, NJ 9/11<sup>Date</sup> 10 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Atlantic City Cem 4 Donation 5 Other (Specify) 22. Name and Address of FacilityHari P. Close F.Svs.PA 5126 Belair Rd,Balt.,MD 21206-5105 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
OVER Year Immediate Cause (Final Physician/ Arterio Sclerotic Cardiovascular Disase disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cardiac Arythmia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician ar s the burial-t Physician/Medical Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 💆 No
9 ☐ Unknown Month Day Year been signed by the should be detached 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Jas 2X No 1 Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certific. director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 X Yes ပ္ 1 Inpatient 2X ER/Outpatient 3 IDOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c License number D 2 4 7 2 1 29d. Date signed (Month, Day, Year) 9/6/10

Registrar
DHMH 17 Rev 7/2009

State

14333 Laurel Bowie Rd. #208 Laurel, Md. 20708

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed A. Sadiq

31. Date filed (Month, Day, Tear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 27960 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ASTLIC AUGUST Year EBBT 12:48 PM Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE MARYLAND MODICAL BALTIMORE RSITY OF GENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Min. Hours Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21229 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 1 ☐ Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify: Black 1 Yes 2 No 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working ife. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6/955 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 3asi I and 2 should b f Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KD eronica Johnson - Sister Bosto. 21229 Kokeb Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Prvice Lice Patr 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. 23a. Patu 1 Approximate Interval Between Immediate Pause (Final Onset and Death ESOPHAG PERFORATION Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy cate has been signed by the atterpage 2 should be detached for a in the past 12 months?

1 Yes 2 No ☐ Pregnant at time of death ☐ Unknown 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy within 24 hours after deam.

To the Funeral Director. After this certificate hampleted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 2 Accident
3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 000 AUGUST 30. Name and address of person who

Registrar DHMH 17 Rev 7/2009

State

MANJUNATH 31. Date filed (Month, Day, Year)

<u>SEP 0 8 2010</u>

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S. GREENE ST, BALTIMORE, MD &1201

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MARKANDAYA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g907 9-14-10 vt
State of Maryland / Department of Health and Mental Hygiene 1 Amend Item#1perPHYS#19a, perINF, G907, 9/27/2010, WS

Certificate of Death Reg. No. 1 - State Registrar Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) Mario 3. Time of Death Physician/ M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Season's Hospice 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Months Days Hours Min. Director 05 213-26-2887 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland "natural", or items 23a or 28a-f sho Director 1 XYes 2 No Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21215 U.S.A. 3412 Grantley Road Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Black Completed 3 X Widowed 4 □ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Park Savage Meat Stuffer 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dorothy Trusty Bernard Gillis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Hall Jeannitte L Grantley Road, Baltimore, Md 21215 3412 Hill-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Owings Mills, Md 9/11/10 Garrison Forest ۷et 4 A Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Eacility
March F/H West
4300 Wabash Ave, baltimore, Md 21215 23a. Parl 1. Enter the dhease, or complications that cause shock, or heart fail the. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ki Physician/ disease or condition resulting in death) Medical Due to (or as a conse vence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of): requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law certificate has the irector, page 2 s autopsy performed? death? 2 🗆 No 1 Tes Yes 2 26. Place of Death (Check only one) Division of Vital Be 25. Was case referred to medical examiner? Hospital 2 **1**00 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, by 4 Homicide determined City or Town, State) filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

∬ State 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2010

10-06424 Paula Black Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paula Black		1- For State	of Maryland / Depa		lealth and Mer		2010	27962
Physicį Medical Exami	an/ iner	Registrar  1. Decedent's Name (First, Middle,Las				2. Date of Dea Month August 2	Dav Year	3. Time of Death 1757 hrs
		4a. Facility Name (if not institution, give Mercy Medical Center	e street and number)		City, Town, or Location Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number 6. Se 217-69-6649 1	7. Age (In yrs. I	ast birthday)  46 Yrs.	If Under 1 Year If Und Months Days Hour		rth(MM/DD/YYYY) 9. Birt 24 1963 Foreig Cou	hplace (State or n untry)
d how any	L	Usual Residence of Decedent  10a. State 10b. County		Town or Location				10d. Inside City Limits 1 Yes 2 No
the Marylan a or 28a-f st	Director	10e. Street and Number	?D	111111111111111111111111111111111111111	0f. Zip Code 21216		log. Citizen of What Coun	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?  1 Yes 2 No	.S. 13. Was D	ecedent of Hispanic Ori specify Cuban, Mexicar	igin? ( Specify Yes or No n, Puerto Rican, etc.)		can Indian, Black,
2 21215-0036  bould be filed within 72 hours after and Mental Hygene, is marked other than "natural", etc event, the Medical Examiner.	Completed by	15. Decedent's Education (Specify on Elementary/Secondary (0-12)	or Dates:	16a, Decedent's	Usual Occupation (Give of working life, DO NOT	kind of work done	16b. Kind of Business/Ir	ndustry
MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene. In 27 is marked other than numatic event, the Medical manic event, the Medical states and a should be should	Be		K JR.		Rosa Rosa		1ery	
ore, MD 2's 1 and 2 should 5'f Health and M If item 27 is miner traumatice	To	19a. Informant's Name/Relationship (Ty Michelle Melto 20a. Method of Disposition	n-Sister	H203 Place of Disposition	Oakford I	nber or Rural Rate Nur Que. Balto Date	nber, lity or Town, State,  MD 212  20c. Location - City or T	15
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		1 Burial 2 Cremation 3 4 Donation 5 Other Specify 21. Signal 4 of Funeral Service L	Removal from State	rematory or other  Memor	ial Park	9-7-10 Uneral Hon	Randalktou	in, Mo
Physician	-	23a. Dan knter the disease, or complife failure. List only one cause on ear	ications that caused the death.	1270	Fredhillm	Pass Balt	o. mi) aldo	Approximate Interval Between Onset and
/Medi_I Examiner		Immediate Cause (Final disease a.	Complications  Oue to (or as a consequence of		static carc	inoma		Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated	Oue to (or as a consequence of	r):				
	dical Exar	events resulting in death) Last d.  X UNPENDED	Due to (or as a consequence of					
E. E. B	3	IF FEMALE: 3b. Was decedent pregnant in the past 12 months?	AMENDED 23a, 27, per 23c. If yes, outcome of pregr	ME G908 nancy 2 Fetal of		c pregnancy	23d. Date of delivery  Month Da	ay Year
Box 68760 he death certificate I y the attending physical performs as the broad of the deforms as the broad of the deforms as the broad for use as the broad	Physicia	1 Yes 2 No 9 V Unknown	4 Pregnant at time of dea	J Other	(Specify)			
ls, P.O quires that t en signed b	اھ	Part II. Other significant conditions	contributing to death but not re	suiting in the unde	riying cause given in Pa	1 Yes	bacco use contribute to the	bly 4 🗹 Unknown
tal Records, cian: The law requirectificate has been secrificate page 2 should	Completed					24a. Was a autop perfor	sy prior to co med? death?	psy findings available mpletion of cause of 2 No
F-Vital Rec Physician: The or this certificate	To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death		ER/Outpatient 3		Nursing Home 5	Residence 6 Other:	
Division of Vital Records, P.O. Box 6876( the Hospital or Attending Physician: The law requires that the death certificate thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phys npletely filled in by the funeral director, page 2 should be detached for use as the b	Certification:	1 Natural 5 Pending Investigation	(Month, Day, Year)	28b. Time of Injury	1 Yes 2	No	now injury occurred	al Route Number, City
Division  Hospital or Attendi 24 hours after death. Funeral Director: , etely filled in by the fi		4 Homicide determined 29a. Certifier 1 Certifying Physicia	(Specify) n: To the best of my knowledg			or Town, Since, and due to the cause	tate)  e(s) and manner as stated	1.
To the Hos within 24 h To the Fur	Medical	29b. Signature and title of certifier	On the basis of examination an and manner stated.	id/or investigation,	in my opinion, death occ 29c. License number	curred at the time, date a	and place, and due to the 29d. Date signed (Monti	
	-	30. Name and address of person who co	empleted cause of death (Item :	23a)	O.C.M.E.		August 26, 2010	
Ø J				Penn Street, E	saltimore, MD 212	01		
Sta Registi		ST. Date filed (Month, Day, Year)		A hour	Kel			

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September . Physician/ **GEORGE** BUETTNER JR. \_p <sup>M</sup> 9:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Hospice Timonium 8. Date of Birth Month Day Year May 25, 1923 If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2 D F 216-14-8085 Maryland 87 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Director notified Maryland **Baltimore** Timonium 1 🗆 Yes 2 ื No 28a-f 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a on the Medical Examiner must be Funeral 2300 Dulaney Valley Road 21093 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 No þ White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Archdiocese of Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Clergy 7 is marked other traumatic event, t Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) George J. Buettner ٥ Sr. Lena Krueger 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Medici Court, Parkville, Maryland 21234 Bernard B. Lowekamp Department of Health Important: If item 27 any injury or other the once. Representative) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 09-07-10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Qther (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funer Service Licensee 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h, sician/ CONGESTIVE HEART FAILURE sease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 No Other (Specify) 1 ☐ Yes 2 🕱 No HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: X Natural 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be within 24 hours after deat To the Funeral Director: completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Certifying Priystoran: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title

State

GEORGE BUETTNER

Registrar

DHMH 17 Rev 7/2009

**JACKIE** 

31. Date filed (Month, Day, Year)

JONES

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Richard Belcastro 12:45 A M August 2010 Sept<u>ember</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dundalk Genesis Eldercare - Heritage Baltimore 8. Date of Birth (Month, Day, Yea October 15, Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 D F Months 215-09-1443 Director 89 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Examiner must be notified at Director N/A Baltimore Md. 1 √ Yes 2 No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6421 Hartwait Street 21224 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 0 1 ☐ Never Married 2 🙀 Married Completed by 1 X Yes a 2 No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h h and Mental Hygiene. ?7 is marked other than "n (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Furnace Operator Bethlehem Steel 6 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Belcastro Rose Ferrera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a tant: If item 27 is Lena Belcastro Wife 6421 Hartwait Street, Baltimore, Md. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) September Sacred Heart Of Jesus Cem, Dundalk, Maryland 2010 21. Signature of Funeral Service Licensee. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md.

23a. Part 1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, should be cause on each line. 22. Name and Address of Facility Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) **Examiner** Nu: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam that the death certificate be executed the burial-tran that initiated events resulting in death) Last Physician/Medical Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 📝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ellet- Place Dundalk MD State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Viola Deloris Cook /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 □ F 103-34-6057 Director 65 10-5-1944 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Evan in permust be nothed at 1 ☐ Yes 2X No Director MD Rosedale Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21237 41 Libra Court Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes a No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo ð Specify: Black Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Social Worker th and Mental Hygie 7 is marked other to Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Menia Important: If item 27 is marked any Injury or other traumatic evonce. Jessie Clanton Ruth Edith Kearney ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Willette Brandon-Sister Rosedale, MD 21237 <u>Libra Ct</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 9-3-2010 BALTO, MD March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service tricensee 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onsetland Death 23a. Part 1. Ent. r the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. dying\_such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mg 5 ☐ Other (specify) 1 ☐ Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 100 24a. Was an page 2 s autopsy perform certificate 2 □ 1 ∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ 1es 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 SER/Outpatient 3 DOA 1 Inpatient ၉ this 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a **To the Funeral D**completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and the of certifier BV HOSP CENTUR BULLMORE MD 21237 State

DHMH 17 Rev 1/2001

Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUG. Physician/ MARY E. 30°, 201°0° CAREY 8:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner STELLA MARIS TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) PA. 1 🗆 M 2 💢 Days Months Hours Min o*#%259*2010 198-14-0325 87 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State Funeral Director 1 

Yes 2 □ No MD. N/A BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7142 GOUGH STREET 21224 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married filed within 72 hours after 21215-0036 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES CLERK RETAIL Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental cant: If item 27 is marked or ဂ္ ELIZABETH KANDRA GEORGE SHIMO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNADETTE ROCHE/DAUGHTER 7142 GOUGH ST., BALTIMORE, MARYLAND 21224 or other 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State AUGUST Department of Important: If its any injury or of OAK LAWN CEMETERY BALTIMORE, MARYLAND 9/2/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fineral Service 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a Bert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ END STAGE CARDIAC DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) the burial attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 - Fetal death for in the past 12 months? Month Year Dav Pregnant at time of death g 🗌 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 X No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: မှ HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached CAREY Medical only one 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY RD. JONES, SEP 0 8 2010

Registrar

3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TIMONIUM, MD 21093

2010

10-06501 Devon Odell Corey

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	ertifica	ate of	Death			Re	eg. No.	201	0 2/96
Physicia	in/	Decedent's Name (First, Middle,Last)						Date of Deat	th Day Y	.ar	3. Time of Death
Medical Exami		20,011 10011						August 28, 2010			1152 hrs
2		Facility Name (if not institution, give street and number)  Upper Chesapeake Medical Center	4b. City, Town, or Location of Death Bel Air					4c. County of Death Harford			
Funeral		opper oncouponic modern contex							Y) 9. Bir	thplace (State or	
Director		Myonths Bays Hours Min. 10_08_2009 Foreit							untry) MD		
	ŀ	220-85-2688   1\( \times \)									
any	ı	10a. State 10b. County 10c. 0	City, Town	or Locatio	on						10d. Inside City Limits
Aaryland 28a-f show 1 at once.	Director	MD Harford	Stree	t							1 Yes 2 No
Maryla 28a-f d at o		10e. Street and Number			10f. Zip Code			11	0g. Citizen of V	hat Coul	ntry?
15-0036 filed within 72 hours after death with the Maryland Hygiene. 54 other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once.		3320 Forge Hill Rd			21154			1	USA		
th with	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces? Armed Forces?	n U.S.		Decedent of Hisp es, specify Cuban,					e - Ameri te, etc.	can Indian, Black,
er dea	ᇎ	1 Yes 2 X N 3 Widowed 4 Divorced If Yes, Give Year	lo	1	Yes 2X No	specify:			Specify:	B1a	ack
irs aft tural"	ğ	or Dates:  15. Decedent's Education (Specify only highest grade completed		Decedent	s Usual Occupation	on (Give k			16b. Kind of B		ndustry
5-0036 led within 72 hours Hygiene. other than "natur	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	<b>⊣</b> '	-	st of working life. [	DO NOT (	use retired	1)		,	
036 rithin and and and and and and and and and an		n/a n/a		n/						n/a	
5-0 iled w Hygio		17. Father's Name (First, Middle, Last)						irst, Middle, M Corey	Maiden Surnam	e)	
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	Anthony W. Joseph Jr.  19a. Informant's Name/Relationship (Type, Print)	191	Mailing	Address (Street					wn State	Zin Code)
MD 2 d 2 shoul Ith and M n 27 is n	٩	Zakkiya M. Corey (Mother)	3	320	Forge Hi	11 R	d Sti	eet, N	D 2115	4	, 2.15 0000)
imore, MD 2  Pages 1 and 2 shou nent of Health and N iant: If item 27 is n or other traumatic		20a. Method of Disposition			tion (Name of ceme	etery,		Date	20c. Location	- City or	Town, State
Baltimore, permit. Pages I and Department of Heal Important: If iten		1 XBurial 2 Cremation 3 Removal from State		ory or other	C Cemete:	ry (	09-04	-2010	Bel A	ir, N	Œ
altin nit. P sartme sortai	- 1	4 Donation 5 Other Specify: 21. Signature of Funer - Secce Licensee					Schir	nunek I	Tuneral	Home	e of BelAir
R P P E		min D. form		Inc	610 W.	MacP!	hail	Rd Bel	lAir, M	D 21	014
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the de failure. List only one cause on each line.				such as ca	irdiac or r	espiratory arre	est, shock, or h	eart	Approximate Interval Between Onset and
Examiner		inimediate Cause (i inal disease a.		ntox:	ication						Death
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P.O. Besthat the d	by P	Part II. Other significant conditions contributing to death but n	ot resulting	in the ur	nderlying cause giv	ven in Par	t I.				the cause of death?
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ord w req as bee	plet							24a. Was autop			topsy findings available completion of cause of
Rec The Iz cate h	Completed							1 Yes		1 Y	es 2 No
Division of Vital Records, ral or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2	. # EDIC		26.Place o	Othor: -			Residence 6	Other	
of Vi	입	1 Yes 2 No Inpatient 2  27. Manner of Death 28a. Date of Injury		Time of In					now injury occu		
nding Pl th. : After	Ö	1 Natural 5 Pending fd. 8/28/10	fd.		01am 1□ Ye		- 1	ınk.			
'isiC	icat	2 Accident Investigation 28e. Place of Injury - A		rm, street	t, factory, office bu	uilding, etc	. 2			ber or Ru	ral Route Number, City
Division  Hospital or Attence 24 hours after death Funeral Directorately filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Residence Could not be determined (Specify) Residence 3320 Forge Hill Rd. Specify								d.Street,MD	
Hosp 24 ho Fune		29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Additionally one of the cause									ed.
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical	and manner stated.	on and/or ir	vestigatio			curred at t	ne time, date			
	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Mont  O.C.M.E.  OCME  August 29, 2010							ткп, Day, Year)		
		Theodor W. Roy JR.	u.	d.	0.0.10	··	3011		August 28	, 2010	
10	30. Name and address of person who complete cleause of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
	ate	31 Date filed (Month, Day Year) 32. Registrar's Sign				-					
Regist	rar	SEP 0'8 2010   Deneua	A.	40	Kal						
DHMH 17 Rev 1/20	001		OR	IGINAL	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Monts Physician/ av1011 0 any Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Bactimo or thuest dalistown Mospiter If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number unk 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min Maryland 1 □ M 2 🗓 F Jan 8 Day, 1971 Director 39 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location ıral", or items 23a or 28a-f sho | Examiner must be notified at Director 1 ☐ Yes 2X☐ No Randallstown Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21133 9109 Liberty Road r death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12, Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. \$ 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🌠 No If Yes, Give Maryland 21215-0036 black 1 ☐ Yes 2 🛣 No Specify Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be unk 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last, ည injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21201 647 W. Hoffman Street Baltimore, MD Angela Gregory/cousin permit. Page 1 and 2 Department of Healt Important: If item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Other (Specify) In Stat Ronald e Licensee S - Wa State Anatomy Board 655 W. Baltimore Street Signal MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should E5121 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 21 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No ည 1 Tyes 1 Inpatient 2 PER/Outpatient 3 IDDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation
6 
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Randoustown

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32. Registrar's Sig

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31. Date filed (Month, Day, Year)

SEP 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ 6:30 PM 09 2010 PAUL CHAPMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITAL GOOD SAMARITAN If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Funeral Director 1 Yes 2 ☐ No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe items 23a uneer 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. 2 1 Never Married 2 Married filed within 72 hours after Black Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🐪 Specify 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 7, nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Midelle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Cara Drive aughter item 2 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, cremator Important: It any injury of 21. Signal e License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ CARRIOGENIC SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 48 Hours ISCHEMIC-PILATED CAKNOWYOPATH Sequentially list conditions Examiner Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying as the burial-transit The law requires that the death certificate be executed Cause (Disease or liniury and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No jo. Month Day Year 4 Pregnant Pregnant at time of death 1 ☐ Yes ∠ Iz 9 ☐ Unknown by the be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown ASPIRATION PNEMMONIA, OSTEOMYERITIS Records, Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of PERUPHERAL VASCULOR DISPASE has autopsy performed? death? 2 No HYPOXIC -ISCHEMIC ENCOPHACOPATITY 2 No this certificate 1 Yes Yes 25. Was case referred to medical of Vital or Attending Physician: director, 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 ☑ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at the funeral 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After I completed filled in by the funeri injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural Division Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours af To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) RES-000 09/02/10 anfr- TANNIA H. JOSON

Registrar
DHMH 17 Rev 7/2009

State

RAVEN

BLVD.

LOCH

BALTMORE. MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSON

TANNIA

31. Date filed (Month, Day, Year)

5401

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sept. Year Physician/ PHILIP CARROLL 2010 6:32 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Ellicott City 3483 Manor Lane 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Aug 9, 1924 096-28-5560 Months New York Director 86 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director Ellicott City Maryland Howard 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 3483 Manor Lane 21042 items 23a Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White "natural", 3 Widowed 4 Noivorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. . DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve and injury or other traumatic eve once. and Mental i ပ Philip Acosta Carroll Nina Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) Philip Carroll 3483 Manor Lane, Ellicott City, Maryland 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Ellicott City, Maryland Carroll Family Cemetery Sept 7, 2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility ACully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Servi Licensee kevin E Fcker 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Metastatic 60100 Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) igned by the a be detached f 9 Unknown neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural work? 1 \( \subseteq \text{Yes} 5 Pending s after death. 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the | within 2 To the | only one) 29b. Signature and title 7.2010 42129 13x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William McConnell, M.D. 6311 North Charles ST., Suite 5, Baltimore, Md.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 1 State of Maryland / Department of Health and Mental Hygiene

Charles Abelard	dl C	1- For State	State of Ma	ryland /		artment of tificate of		and Mer	ntal Hy	giene	gibio 201	0 21911
Physici	ian/	Registrar 1. Decedent's Name (First,	Middle,Last)	-		incate of	Dealli		12	. Date of Dea	eg. No.	3. Time of Death
Medical Exam		CHARLES A	BELARDI C	ARLSON						Month Septembe	Day Year er 2, 2010	1403 hrs
and the same		4a. Facility Name (if not ins	titution, give street a	nd number)		4		n, or Location	of Death		4c. County of	Death
		9347 Waynesbord  5. Social Security Number	6. Sex	7 0	//		Emmitsk				Frederick	
Funeral Director						ast birthday)	If Under 1 Months	Year If Und Days Hour	er 24Hrs. s Min.		1	Birthplace (State or oreign
		217-90-4401 Usual Residence of Decede	1 X M 2	<u></u>	37	Yrs.				7/22/	1973	MARYE AND
any		10a. State 10b. Co		10	Oc. City,	Town or Location	n					10d. Inside City Limits
and F show	ō	MD	N/A		B	ALTIMOR	E CITY					1 X Yes 2 No
Maryl r 28a-	Director	10e. Street and Number			-		10f. Zip Coo			1	0g. Citizen of What	Country?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	al Di	3906 FALLS I					212				USA	
ath wi	Funeral	11. Marital Status 1 X Never Married 2		Decedent Eved Forces?		S. 13, Was	Decedent of s, specify Cu	f Hispanic Ori ıban, Mexican	gin? (Spec , Puerto Ri	cify Yes or No can, etc.)	- 14. Race - White, e	American Indian, Black, etc.
fter de		3 Widowed 4	Divorced If Yes, Giv		No	11	res 2	GUATA No specify:	MALAN	r	Specify: WI	HITE
ours a atura	d by	15. Decedent's Education	Specify only highest	grade comple	eted)	16a, Decedent's	S Usual Occu	upation (Give	kind of wor	k done	16b. Kind of Busin	ess/Industry
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_ = 0 = 0		20a. Method of Disposition  1 Burial 2 X Crem	ation 3 Remov	al from State	20b. P	lace of Dispositi ematory or othe		cemetery,		ate	20c. Location - Ci	
Baltimore, permit. Pages la Department of He Important: If ite		4 Donation 5 Othe	er Specify:		MET	TRO CREM	ATORY			/2010	CATONSVI	
Salt ermit, epartu mport ijury		21. Signature of Funeral Ser	vice Licensee MOO	217		22. Na	me and Addr	ess of Facility	THE	JOHNSO	N FUNERAL	HOME, P.A.
	-	20a. Part I. Enter the disease	a or complications th	nat coursed the	donte	852	1 LOCI	H RAVEI	V BLV	D. 170	WSON. MD	21286
Physician /Medical		failure. List only one ca	ause on each line. Meth			xicatio		ng, such as ca	ardiac or re	spiratory arre	est, snock, or heart	Approximate Interval Between Onset ap
Examiner		Immediate Cause (Final dise or condition resulting in deal	ease a.	as a consequ								Death
	L	Sequentially list conditions,	b									
	ine	if any, leading to immediate cause. Enter Underlying Ca	use	as a consequ	ence of):	:						
d sit	Examiner	(Disease or injury that initiate events resulting in death) La	eu	as a consequ	ence of):			-				
(0, e be executed ysician and burial - transit	dical	X UNPENDED	d									
50, te be ex ysician burial			AMENDE	3a,PII	,27,	28a-f,	per M	E g908	10/2	7/10 T	T	
Box 6876( c death certificate the attending phy ed for use as the b	ician/Me	IF FEMALE: 23b. Was decedent pregnant past 12 months?	in the	es, outcome o ve birth	of pregna				pregnancy		23d. Date of del Month	very Day Year
Sox 687 death certific e attending p	so !		Unknown	egnant at time	e of deat	h	(Specify)					24,
the de ched f	Phy	Part II. Other significant con	9	nknown	t not res	ulting in the und	orlying onus	o siven in Dec	4.1	220 Did tol		
Division of Vital Records, P.O. Box 6876( ral or Attending Physician: The law requires that the death certificate rs after death.  al Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the b	ā	Cocaine us		ig to death bu	it not res	alang in the and	errying caus	e gi <b>ve</b> n in Par	τι.	1 Yes		e to the cause of death?  Probably 4  Unknown
ords, w require s been si	Completed									24a. Was a		autopsy findings available
e law e has t	dm									autops perform	y prior ned? deat	to completion of cause of
Rec n: The l tificate h or, page	ပ္ပို	25. Was case referred to med	dical				26 Pla	ce of Death (	Chook only	1 Yes 2	No 1 ✓	Yes 2 No
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	밁	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 E	R/Outpatient 3		Other	Nursing H		tesidence 6 🗸 0	ther: Scene
of ing Ph	-	27. Manner of Death	28a. D	ate of Injury	2	8b. Time of Inju	y 28c. In	jury at Work?		I. Describe ho	w injury occurred	
ivision for Attend after death. Director:	Certification:	5 P		9/2/10	) F	'd 1345	hrs 🗀	Yes 2 X	No Si	ıbject	ingested	metahdone
Nor A safter I Dire	ij		ould not be		- At hom	ne, farm, street, f	actory, office	building, etc.		Location (St.	reet and Number or	Rural Route Number, City Ynesboro Rd
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide							E1111	nitsbu.	rg, MD	
To the H within 24 To the F complete	edical	(Check only one) 2 Medical E	Physician: To the Examiner: On the bas	sis of examina	owledge ation and	, death occurred /or investigation	at the time, , in my opinio	date and plac on, death occ	e, and due urred at the	to the cause time, date ar	(s) and manner as s nd place, and due to	stated. o the cause(s)
To wit	좕	29b. Signature and title of cer	and manne	er stated.				nse number			29d. Date signed (	
		Muca		72 17			0.0	.M.E.		- 1	September 3,	
~#F	+	39. Name and address of pers			•	3a)						
		Russell Alexander N		Medical E		ner 111 Pe	enn Stree	t, Baltimor	e, MD 2	1201 00ME		
Sta Registr		31. Date filed (Month, Day, Ye.		Registrar's S	ignature	harle	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS, G907, 97872010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 31 Day 201 Oar 6:00 P COHEN ALLEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE ATRIUM VILLAGE ASSISTED LIVING OWINGS MILLS If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 0872771911 99 MD Director 578-40-5633 Usual Residence of Decedent 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2722 WOODCOURT ROAD 21209 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🗓 No Specify: WHITE Specify Completed 3 X Widowed 4 Divorced Year or Dates er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRINTING PROOF READING h and Mental Hygien 7 is marked other tl 27 is marked other traumatic event, Be Baltimore, Maryland 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 COHEN DORA GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2205 QUARTERMASTER LANE, RESTON, VA permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once. 20191 DONALD W. COHEN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) BNAI ISRAEL CEMETERY: 09/02/2010 BALTIMORE, MD Sonature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each inc. Approximate Interval Between Onset and Death ath. Do not enter the Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi physician and Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be exec Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ C 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 2 🗌 No 1 Yes Yes 25. Was case referred medical director, Be 26. Place of Death (Check only one) Assisted
6 Other (SpecifyLiving examiner? Other: 4 Nursing Home Certificate: To 1 Typs 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) funeral 27. Man r of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No 1 Yes Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c, License number 23a) (Type, Print) npleted cause of death (Item 31. Date filed (Month, Day, Year) State SEP 0 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2245PM 24 2010 Dewey Overly Davis, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Square Hospital Center Rosedole FRANKLIN 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ₩ 2 □ F 79 Director 216-24-0648 March 13.1931 West Virginia Usual Residence of Decedent 10d. Inside City Limits ia or 28a-f show 10a. State 10h County 10c. City, Town or Location 1 □ Yes 2 No Director Perry Hall Balto. Md. the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examirer must b 8900 Cowenton Avenue 21128 Funeral USA filed within 72 hours after death Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or Completed by If Yes, Give Year or Dates 1947-1947 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced er than "natura 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5 th College (1-4or 5+) Roller Bethlehem Steel altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Dewey O. Davis, Sr. Hazel V. 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra once. 27 Donald E. Davis Son 8900 Cowenton Avenue Perry Hall, Md. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-2-2010 Bel Air Memorial Bel Air, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEDSIS Severe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bacteremia Enterococcus Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for ea a consequence of Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ coronary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown artery Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of death? CHF 24a Was an cate has certificate 10-15% fraction 2 No 1 ☐ Yes 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

1241

DHMH 17 Rev 1/2001

State

Registrar

(Check only

29b. Signature and title of certifier

9000 Franklin

**SEP 0 8 2010** 

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square

Dr

32. Registrar's Signature

pare

Baltimore, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RESODOD

21237

29d. Date signed (Month. Dav. Year)

DRKaherine

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of M	larylan		artment of F tificate of L		ind Mental		0.0	10	27071
			Registrar  1. Decedent's Nam	e (First, Middle, La	st)		<u>Cer</u>	Lincate Of L		2. Date of	Reg. of Death	No	<u> </u>	3. Time of Death
	Physicia Medio		Su	.e	Flemin	ıg		Dodd		Month Septe	ember	Day 2	Year 010	7:34 a <sup>M</sup>
	Examin		4a. Facility Name (if	not institution, give	street and number)			4b. City, Town, or	Location of	Death		4c. County		
-			F. Social Security N	uturecar			-1 ( -11-1-1	Reis	If Under 2		. B			Imore
	Funeral Director		219-30-2. Usual Residence of	543	M 2 ¬xF	76	st birthday) Yrs.	Months Days	Hours		Day, Yea	933	9. Birthp Coun	place (State or Foreign try) MD
	ryland -f show ied at	ctor	10a. State	10b. County		10c. City	, Town or Lo						1	0d. Inside City Limits
	r 28a notifi	Dire	MD 10e. Street and Nur	Balti	more		Rei	sterstow 10f, Zip Code	n		100	Citizen of W	/hat Caum	1 ☐ Yes 2 🛣 No
	with the 23a c	Funeral Director			ing Court				136		109.	USA		цу:
	items er mi	Fun	11. Marital Status	TITIE OPI	12. Was Decedent Armed Forces?			Vas Decedent of H	ispanic Origi	In? (Specify Yes or	No-	14. Race	- Americ	an Indian,
920	ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	β	1 ☐ Never Marr 3 ☐ Widowed	ied 2  Married 4 <b>X</b> Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No No		☐ Yes 2 🔀 No		rueito nican, etc.	,	Specify:	white, e	
5-0	2 hou "natu edical	plet	(Spe	15. Decedent's E			(Give I	ent's Usual Occup	ation during most o	of working	16b	o. Kind of Bu	siness Inc	lustry
21215-0036	should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me	Completed	Elementary/Sec	onday (0-12)	College (1-4 or	5+)	life. Do	ONOT use retired) Secretary	Ü	Ü		Secret	aria	.1
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ylaı	should be file and Mental I 7 is marked o raumatic eve	욘	Arnold	Goering						Sue Pow	ers			
Maryland	2 shouth and the and the street of the stree		19a. Informant's Na	• •	., .			g Address (Street						,
	I and I Heali item 2		Richard 20a. Method of Disp	H. McCon	nas Son	20b. P	lace of Dispo	alling S sition (Name of		Date		. Location -		
ШO	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 4 ☐ Donation	∏ Cremation 3 ☐     5 ☐ Other (Speci	Removal from State (fy)	' l		atory`or other plac remation		9/4/2010		Hampst	tead.	MD
Baltimore,	permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr		21. Signate of Fu	neral Service Licen	M. Qon	Ku	22	Name and Addres	ss of Facility	11824	Reist		wn Ro	
			23a. Part 1. Enter t	he disease, or com	plications that cause one cause on each lin	d the death	7					, cowii,		Approximate
	Physician/		Immediate Cause ( disease or condition	Final	/ 1		SNIA						1	Interval Between Onset and Death
-	Medical Examiner		resulting in death)	ſ	Due to (or as	a consequ	ence of):	1 in						
	R. C. L.	ner	Sequentially list co	nmediate	b. Due to (or as	a c equ	ence of):	<del>כ</del> ל ו (עו	/	\ .			ŀ	
	uted nd ransit	cami	Cause Enter Under Cause (Disease or that initiated events	iinjury	с	28	19BR	OUASCWI	AR C	S5A8	E			
_	cate be executed physician and s the burial-transit	edical Examiner	resulting in death) I	ast	Due to (or as	a consequ	ence of):							
160		_			d							_		
Box 68.	or Attending Physician: The law requires that the death certifica after death.  Sirector: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as t	Physician/N	IF FEMALE: 23b. Was decedent in the past 12 1 1 ☐ Yes 2 1 ☐ Unknown	months?	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown	2 Fetal	Ideath 3	Ectopic pregnand Other (specify)	Ç		_	23d. Date Mor	e of delive	ory Day Year
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ord	require been si should	lete									Vas an	24b. W	/ere autop	osy findings available
Rec	sician: The law certificate has irector, page 2	Completed						-11-11-11-11		1 🗆 !	autopsy performed Yes 2	? d	rior to cor eath? Yes	npletion of cause of 2  No
/ital	sician certif lirector	To Be	25. Was case referrence examiner?	_	Hospital:	:t 0 🗆 I	ER/Outpatien	Othe	W .	sing Home 5 1		ه ۱۲ ما	(0 ::()	
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Division of Vital Records,	To the Hospital or Attending Pl within 24 hours after death.  To the Funeral Director: After the completed filled in by the funeral	Certificate:	3 Suicide 4 Homicide	6 Could not be determined				et, factory, office		28f. Locati	on (Street Town, St		r or Rural	Route Number,
П	Hospita 24 hours Funeral eted filled	Medical			sician: To the best of									
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			7//		Char	ر 		100	2506	_	DE	Well	BIL	2,2010
			KANUSS	ess of person who	completed cause of a	eath (Item	23a) (Type, P	are #50	3 Bm	TIMONE.	, NA	ughs.	4) 2	21209
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 1 perphys. G907.9/8/2010. WS
State of Maryland / Department of Health and Mental Hygiene. 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vincent Dixon 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number)
Season's Hospice 4b. City, Town, or Location of Death Randallstown **Examiner** 4c. County of Death more If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral №** M 2 □ F 60 Months 8/10/1950 Country) 216-54-4515 Director Yrs MD Usual Residence of Decedent 28a-f show 10b. County 10a, State 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director iral", or items 23a or 28a-f sl Examiner must be notified Baltimore MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' USA Funeral 21229 Cobber Lane 32 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc.
Black þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) General Maintenance Worker Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Shirley Robertson ೭ Robert Sr. Dixon 19a. Informant's Name/Relationship (Type, Print)
Tiffany N. Norfleet/Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
32 Cobber Lane, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State Final Journey Crem. 9/3/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Maryland Cremation Services eral Service Licenses Dorota Marshall laisha 1413. Baltimore, MD21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Embo Physician/ monau disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the bunal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? ate has been signed by the atterpage 2 should be detached for Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 2 No 1 Yes ☐ Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? वि Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural injury 5 Pending s after death. Accident Investigation 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ertific Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 2, 2010 4:34 P Gerald Micheal Dean Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** <sup>Year)</sup>1951 1 🖾 M 2 🗆 F Months Hours June I1 **Director** 222-36-1914 59 Yrs Pennsylvania Usual Residence of Decedent init. Page 1 and 2 should · e filed within 72 hours after death with the Maryland cartment of Health and M-ntal Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shoininy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🔼 No Maryland Harford <u>Abingdon</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 USA 3800 Washington Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ➡ Yes 2 ☐ If Yes, Give Year or Dates. 1 Yes 2 No Specify Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Splicer Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gerald Arthur Dean Merl Marie Allman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Dean / Wife 3800 Washington Ave., Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nill Mem. Park 9-7-10 Baltimore, Maryland per it. P Departm Importa any inju 21. Signature of Faneral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) RECTAL CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown To Be Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗌 No Yes 2X No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending Investigation

attending physician and for use as the burial-transii Hospital or Attending Physician: The law requires that the death certificate be Box 68760 Division of Vital Records, P.O. has I Director: A

show

Maryland 21215-0036

4:34

PLEMBER Baltimore,

within 24 hours after do

To the Funeral Direct

completed filled in by t

Medical

JACKIE JONES, 31. Date filed (Month, Day, Year) State

29a. Certifier

Suicide

4 🗌 Homicide

only one)

29b. Signature and til

CRNP

6 Could not be

determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date siggled (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medica! street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1timore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** Min Director or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 2.12 39 15A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' econday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, Horalts injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rounsuille. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ MO Cercin ma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 ası IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 2 No detached 9 🗌 Unknown 9 Unknown g signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy the Hospital or Attending Physician: The Yes 1 Yes 25. Was case referred to medical Division of Vital funeral director. Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending 2 No within 24 hours after death. To the Funeral Director: A Accident Investigation the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier 🖷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANDR 31. Date filed (Month, Day State SEP 0 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 XYes 2 □ No

Approximate Interval Between

Onset and Death

Year

Day

2 No

month

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM# 20b, perFH, G907, 9/8/2010, WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Year Physician/ DIMOFF 05:58 A M 2010 LILLIAN 04 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore City Baltimore Levindale 5. Social Security Number 8. Date of Birth DEC 1, 1929 g. Birthplace (State or Foreign MD untry) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 M 2 F Director 80 214-24-7834 Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director N/A YX Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2434 W. BELVEDERE AVENUE 21215 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 XXNever Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NONE NONE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DIMOFF MINNIE GERSHKOVITZ ABRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7902 BRYNMOR CT #506; BALTIMORE, MD 21208 NADINE RUDO / NIECE 20b. Place of Disposition (Name of cemetry gramatory or other place)
BETH TSRAEL ADATH ISRAEL 20a. Method of Disposition 20c. Location - City or Town, State 1 XX Yurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-7-201d BALTIMORE, MD Signature of Funeral Server License e 22. Name and Address of Facility SOL LEVINSON & BROS 21208 Part 1. Enter the disease, or complication shock, or heart failure. List only one day that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of) if any leading to immedicause. Enter Underlying Cause (Disease or iinjury ed by the attending physician and detached for use as the burial-transi To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by templeted filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \square Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1. Natural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064533 09-04-2010 Ptitsiann LEVINDALE W. BE-LVEDERE 2434 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21215 BALTIMORE (Mi) AJANI 31. Date filed (Month, Day, Year) SEP 0 8 2010

State Registrar

32. Registrar's Signature

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 550 PM Mildred Danielczyk Μ. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Rosedale Balti more 8. Date of Birth (Month, Day, Tanuary 1 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Hours 1 □ M 2√2 F Months Days Min. 219-05-8340 88 Maryland Usual Residence of Decedent 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Md. Baltimore Dundalk 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1947 Searles Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify: Completed by Specify: White 3 Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tin Sorter Steel 6 years Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Smith Mary Lamke ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. 7214 Birch Ave. Baltimore Md. 21222 Geraldine Niedoba Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) September 7, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Lutheran Cem. 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. withou Part 1. Enter the disease, or complications that caused the dean. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1 Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final 1+15 **Physician** ,01 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760. physiciar Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? for Month 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 □Yes 2 No 2 □ No After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Krims/r 32. Registrar's 9000 Franklin Square Drive silliam 31. Date filed (Month, Day, Year) State SEP 0 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

10-06584 William J. Der Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

illiam J. Der	1- For State	te of Maryla		tment of		Mental H		2 0 Reg. No.	10 2798	
Physician/	1. Decedent's Name (First, Middle						2. Date of Dea	ath Day Year	3. Time of Death 0710 hrs	
ledical Examiner	William  4a. Facility Name (if not institution	J.,		Der  4t	. City, Town, or I	Location of Deat		er 1, 2010 4c. County o		
ear 1	324 Wicklow Road				Glen Burnie	100		Anne Aru		
Funeral Director	212–32–9297	5. Sex 1 x M 2 F	7. Age (In yrs. las		Months Days	If Under 24Hr Hours Mir	_		9. Birthplace (State or Foreign Country) Maryland	
faryland 28a-f show any 1 at once. ector	Usual Residence of Decedent  10a. State 10b. County  Md. Ann  10e. Street and Number	e Arundel		own or Location		Burnie	1	10g. Citizen of Wh	10d. Inside City Limits  1 Yes 2 No	
3a or 28	10e. Street and Number 10f. Zip Code 21061 US									
Imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Eximiner must be notified at once.  To Be Completed by Funeral Director	(4.4)	Armed Formation 1 Yes  road If Yes, Give Year	2 X No	If Yes		panic Origin? ( S Mexican, Puerto specify:		White	-American Indian, Black, , etc. White	
hours a fracture Ex mi	15. Decedent's Education (Speci Elementary/Secondary (0-12)	fy only highest grad				on (Give kind of DO NOT use re		16b. Kind of Bus	siness/Industry	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Ex.	6 years		10101)		Longshor	reman		Wa	terfront	
21215-0036 buld be filed within 7 Mental Hygiene. marked other than it event, the Media FO Be Comple	17. Father's Name (First, Middle, I Gin Der	,				Ма	rion Wo	-		
mnd 2 should and 2 should ealth and Me tem 27 is ma traumatic every	19a. Informant's Name/Relationsh Shirley M. Ros		ıghter					mber, City or Town		
Baltimore, MC bernit. Pages 1 and 2 s Department of Health a Important: If item 27 njury or other traum	20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Spe	_	om State cr	ace of Disposition of the View Cre		Se	Date otember 2010		City or Town, State	
Baltimo permit. Page Department of Important: injury or oth	21: Signature of Funeral Service L	icensee	lli	22. Na CO:	ne and Address	of Facility uneral	Home Of	Dundalk	, P.A. , Md. 21222	
Physician /Medical Examiner	23a. Part I. Enter the disease, or c failure. List only one cause of Immediate Cause (Final disease	n each line.	ensive at						Approximate Interval Between Onset and Death	
Examiner	or condition resulting in death)  Sequentially list conditions,	Due to (or as a	consequence of):	compli	cated b	y drown	ing			
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c.	consequence of):							
cuted nd transit	events resulting in death) Last	Due to (or as a	consequence of):					<u>_</u>		
be executed sician and nurial - trans	X UNPENDED	☐ AMENDED 23a,	PII,27,	,28a-f,	per ME	G907 9/	23/10 T	T		
Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the buledical Certification: To Be Completed by Physician/Mee	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn	1 Live bi	outcome of pregna irth ant at time of deat	2 Fetal	death 3 [	Ectopic pregn		23d. Date of o	delivery Day <b>Ye</b> ar	
P.O. B as that the d gned by the detached I by Phy	Part II. Other significant condition					ven in Part I.			oute to the cause of death?	
ords, P.O.  v requires that s been signed to should be deta	Diabetes mell		l-stage 1	enal d	sease;		1 Ye		Probably 4  Unknown  /ere autopsy findings available	
Division of Vital Records, tal or Attending Physician: The law requires after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed	<u>seizure disor</u>	der					auto	psy pr prmed? de	rior to completion of cause of eath?  Yes 2 No	
ital   sician: s certifi irector,	25. Was case referred to medical examiner?	Hospital:	npatient 2 E	R/Outpatient		of Death (Check	only one)	Residence 6	Other: Scene	
of Ving Phys After this uneral di n: To	1 Yes 2 No 27. Manner of Death	28a. Date	·	28b. Time of Inju	iry 28c. Injury	at Work?	28d. Describe	how injury occurre		
Division o spital or Attending nours after death. neral Director: After filled in by the fune Certification:	1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation Fd 9/	1/10 I	Ed 6:59 ne, farm, street,	am	es 2X No	his ba	thtub	r or Rural Route Number, City icklow Road	
Diversity of thous all uneral Diversity filled	4 Homicide determ	nined (Specify)	resid		d at the time, dat	e and place and		·		
To the Hos within 24 h To the Fur completely	one) 2 Medical Exam	iner: On the basis o	of examination and	d/or investigation	n, in my opinion,	death occurred	at the time, date	and place, and du	e to the cause(s)	
2	29b. Signature and title of certifier	_			29c. License			29d. Date signer September	d <i>(Month, Day,</i> Year) 1, 2010	
	30. Name and address of person v Donna M. Vincenti, MD		e of death (Item 2 ledical Exami		enn Street,	Baltimore, M	ID 21201			
State	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature	del						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Μ. Ellison Johnnie Physician/ 30° 20°T'0 20:59pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Memorial Hospital Havre De Grace Harford Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) Funeral Hours Min (Month, Day, Year) 8-23-1946 1 □ M 2 🛣 F Director 420-60-8245 64 AL Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Irvington 1 🗆 Yes 2 🛂 No N.J. 10e. Street and Number 10g. Citizen of What Country?
USA 07111 Funeral 714 Chancellor Avenue Apt 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "nether any injury or other transmissions." Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Specify: Black 1 ☐ Yes 2 X No Specify: 3<sup>★</sup> Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Treat Elementary/Seconday (0-12)
12th grade College (1-4 or 5+) Theater Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola Grace Johnnie Key 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark C. Ellison-Son Baltimore, MD 21206 4909 LaSalle Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 9-5-2010 Columbia, Alabama lst Baptist Ch 22. Name and Address of Facility March East F/H MML Balto, MD21202 101 E. Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause Final Onset and Death Physician/ pertensive disease or condition minutes Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital Other: 2 \ No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of s after death. I Director: After t Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) within 24 hours a To the Funeral D 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G907 9/08/10 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09 2010 Annie M. Ebron 8:30 рм Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 5705 Jonquil Avenue 8. Date of Birth (Month Bay, Year) 03-02 1939 Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕱 F N.C. Director 237-64-1497 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 5705 Jonquil Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3X Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Store Owner Self Employed na Be 18. Mother's Name (First, Middle, Maiden Surname)
Allie Mae Mann 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filt.
Department of Health and Mental
Important; If item 27 is marked of
any injury or other traumatic eve Henry Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3406 Ingleside Ave, Baltimore, Md 21215 19a. Informant's Name/Relationship (Type, Print) Sebastian Clark-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 9/4/2010 Baltimore, Md March West Signat re of pneral Service Li 22. Name and Address of Facility de 21215 4300 Wabash Avenue Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CUNIER ーレヘロ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine tue to for es e consequence of: if any, leading to immedicause. Enter Underlying attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 - Fetal death In the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a Id be detached I P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, pag 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 40854

Registrar

DHMH 17 Rev 7/2009

State

227 St. Paul Place

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

31. Date filed (Month, Day, Year) SEP 0 8 2010

4/3/2010

タノかのゴ

Bultimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year John Daniel Fullmer 1625 September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Min. 215-62-6728 Hours Country) 53 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis MD1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1170 Neptune Place USA 21409 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Counselor Crisis Intervention Be 18. Mother's Name (First, Middle, Maiden Surname)
Gloria DelVecchio 17. Father's Name (First, Middle, Last) ပ Marvin Richard Fullmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 355 Epping Way, Annapolis, MD 21401 19a. Informant's Name/Relationship (Type, Print) Nancy Fullmer / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State 9/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Depsis Medical resulting in death) Due to (or as a consequence of): **Examiner** 5 days Nectotizina Fasciitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): law requires that the death certificate be executed physician and s the burial-transit End-stage liver disease that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No detached a 🗌 Unknown as been signed by the should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy Hospital or Attending Physician: The 24 hours after death. 1 Yes 2 No this certificate Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 128 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🗹 Natural 5 Pending injury 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: 
completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1/🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

**Division of Vital** 

W Lexington Street, Apt. 1305

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Katakam

Hartha

NPI:

1316262876

September 4, 2010

Baltimore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav JEBST 03:11 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MARYLAND NIA MEDICAL BALT TMORE If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** 1 □ M 2 💢 F 212-26-7175 81 Months Days Hours Min. 12-22-1928 Director MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Bel Air 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 555 S. Atwood Rd #102 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Curl Cafeteria Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည should be William Lotz Rose Kaptian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health an Important: If item 27 is 1 Bernard Gerst (Son) 1993 Gulf Stream Ct Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley 09-03-2010 Timonium, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility . Scrature of Funeral Service Licensee s of Facility Schimunek Funeral Home of BelAir MacPhail Rd BelAir, MD 21014 610 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical ntractania disease or condition resulting in death) Due to (or as a consequence of) Examiner Bacterenia Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury due to for as a nonsequence off for use as the burial-transi signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day Year be detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗷 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation ☐ Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direc Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 1174781611 08/30/2010 101 address of person who completed cause of death (Item 23a) (Type, Print) TREGORY 22 BALTIMORE

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29 at Por Mary 16907 Department II Health and Mental Hygiene amend #10d&f,19a&b Per FH Centificate of Death Jh 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ sept Day 010 Year 7 2:46P Sharon Kaye Gist Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Carroll Hospice Dove House Westminster 5. Social Security Number 7. Age (In yrs. last birthday) 53 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) MD Hours 1 🗆 M 2 🔀 F 11-20-1956 216-72-5689 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Carroll Westminster 1 X Yes 2 No 10e. Street and Number 21157 21158 10o. Citizen of What Country? Funeral 701 Lythe Hill Ct. USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natur. Iury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Gas & Electric 12 Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Charles Williams Shirley Manus 19a. Infrantis Sam Bruce Gist husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 701 Lythe Hill Ct., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/10710 1 XBurial 2 Cremation 3 Removal from State Important: Is any injury or Krider's Cemetery 9/9/10 Westminster, MD 4 Donation 5 Other (Specify) Signatur of neral Service Licensee Fletcher Funeral 22. Name and Address of Facility Homas Z 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **ENJEABLY** Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in modilate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for se's nonecousings of: Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Frobably 4 Unknown in by the funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗗 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | PATE F 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 🗌 Yes 2 🔲 No Accident Investigation 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature d title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) ter Street Westminster, 4D 2157 32. Registrar State Registrar

DHMH 17 Rev 1/2001

State Registrar

SAIMA

31. Date filed (Month, Day, Year) SEP 0 8 2010

Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

**Division** 

PARKVILLE

MD

30. Name and address of person who completed cause of death (ten 23a) (Type, Print) KHAWAJA, M.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010

		ľ	For State Registrar			Certificate of I			Reg. No.	27987
	Physicia	n/	1. Decedent's Name (First, Middl	,			<del></del>	2. Date of Dea		3. Time of Death
(I)	Medic	al	Diane Rose Ha					Month 09	06 2010	5:15 AM M
	Examin		4a. Facility Name (if not institution	· -		4b. City, Town, o	r Location of Death		4c. County of Deat	
	Funeral	1	Gilchrist Hops 5. Social Security Number	sice   6. Sex	je (In yrs. last birtho	Towson  fav) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Baltimo	hplace (State or Foreign
	Director		216-28-0088	1 □ M 2 🔀 F		rs. Months Days	Hours Min,	06/08/1		untry)
	land show d at	_	Usual Residence of Decedent  10a. State 10b. County		100 City Town	au Location				
	ırylan a-f sh ied a	cto	· · · · · · · · · · · · · · · · · · ·	timore	10c. City, Town of Fork	or Location				10d. Inside City Limits  1  Yes 2 No
	he Ma or 28,	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	
	with the 23a cast be	Funeral Director	6418 Brinton	Lane		21051			U.S.A.	unity?
	items items er mu	Fun	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  By any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 Never Married 2 Mail	ried 1 Yes 2 K	No	1 Yes 2X No		nican, etc.)	Black, White Specify: Wh	e, etc. Lite
15-(	72 hou n "nat fledica	nple	(Specify only high	nt's Education est grade completed)	(9	Decedent's Usual Occup Give kind of work done of fe. DO NOT use retired)	during most of work	king	16b. Kind of Business	Industry
212	within giene. er tha	Cor	Elementary/Seconday (0-12)	College (1-4 or	0+)	Supervisor			Seagrams	Distillary
P	al Hyg d oth event,	Be C	17. Father's Name (First, Middle,	Last)		•	18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
yla	uld be file Mental narked c	မ	Belva Davis S	igmon			Iva Lut	ichia T	incher	
Mar	shou h and 7 is m traum	- 1	19a. Informant's Name/Relations		19b. I	Vailing Address (Street	and Number or Rur	al Route Number	r, City or Town, State, Zip	Code)
	and and Healt Healt tem 2		Shari E. Zak	ielarz (dau		118 Brinton Disposition (Name of		Cork, Ma	ryland 21 20c. Location - City or	051
nor	age 1 ent of ht: If ii y or o		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (		cemetery,	crematory or other place	ce)		•	,
Baltimore,	permit. Page Department of Important: If any injury or once.		21. 5 g tu of Funeral Service I		IHOTTA E				Baltimore, ahn Funeral	
Ä	Depar Impol any ir	)	Mostor	Bohn (					ville, Mary	
			23a. Part 1. Enter the disease, shock, or heart failure. List	complications that cause only one cause on each line	the death. Do not e.	enter the mode of dyin	ig, such as cardiac	or respiratory arr	est,	Approximate Interval Between
~P	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Men	ingitis,	bacteria	/			Onset and Death Wee K2
1	Examiner			Due to (or as	a co sequence of)	absence				
6		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as	a consequence of)	0193(617				
1	nd ransit	Examiner	that initiated events	с						
_	cian a		resulting in death) Last	Due to (or as	a consequence of)					
8760	icate be executed physician and stransit.	Medical		d						
89	attending I for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	3 Ectopic pregnanc			23d. Date of deli	very
Box	Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 ☐ Yes 2 🐼 No 9 ☐ Unknown	4 Pregnant a	t time of death	5 Other (specify)			Month	Day Year
P.O.	ned by	by Pi	Part II. Other significant condition	ons contributing to death b	out not resulting in	the underlying cause give	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ds,	quires en sig ould b	ted	·					1 🗆 🗅	res 2 No 3 □ Pr	obably 4 🗌 Unknown
Records,	has be	Completed						24a. Was a	sy prior to c	opsy findings available ompletion of cause of
Be :	icate l							1 🗆 Yes	med? death? 2 No 1 ☐ Yes	2 No
/ital	certif	m	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		Oth	ace of Death (Chec.		Δ.,	1/ -
of Vital	er this	e: 10	27. Manner of Death	28a. Date of inju		ne of 28c. Injury	4 ∐ Nursing Hoy y at		ence 6 Other (Special Communication of the Communic	M) lowspice
Lo .	arth. or: Aft	licat	1 Natural 5 Pendir 2 Accident Investi	gation	y, Year) inju		? Yes 2 □ No			
Division	after de Directo	Certificate:	3 Suicide 6 Could 4 Homicide determ			, street, factory, office		28f. Location (Si City or Town	treet and Number or Run n, State)	al Route Number,
	hours uneral	Medical	29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, de	ath occured at the time	, date and place, ar	nd due to the cau	use(s) and manner as stat	ted.
	e F		only one) 3 L Certifying	xaminer: On the basis of e Nurse Practioner: To the	best of my knowled	ge, death occurred at the	e time, date and plac	ce, and due to the	cause(s) and manner as s	stated.
ŧ	事事 第		29b. Signature and title of certifier	1 1		29c. License	e number		29d. Date signed (Month,	Day, Year)
£	Within Comp		1 km- n - 12/	l - h		1000	6 1100	1	Sept. 6 2	0/0
	within To the Comp		poron 86	who completed cause of d	eath (Item 23a) (Tvi		61199		Sept. 6, 2	010
	within		30. Name and address of person  30. Name and address of person  31. Date filed (Month, Day, Year)	V 1-1-11	eath (Item 23a) (Typ	oe, Print)	61199 suson		Sept.6, 2	010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HENDRICKS Day Physician/ Month ANNIE 8:52 AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9048 Meadow Heights Road Randallstown Baltimore If Under 1 Year I If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 🗹 Days Director C8-29-1921 240-22-3227 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the M-dical Examiner must be notified at Director Randallstown 1 ☐ Yes 2 X No M Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 21133 9048 Meadow Heights Road USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc 1 Never Married 2 Married 2 💢 No Maryland 21215-0036 1 ☐ Yes 2X No Specify: African-American If Yes, Give Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Damestic Housewife 12th event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Department of Health and Department of Health and Menta Important, if item 27 is marked any injury or other traumations. ဥ Joseph Perry Effie Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9048 Meadow Heights Road, Randallstown, MD 21133 Joan Hendricks/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-9-2010 Arbutus Memorial Park Arbutus, MD tuge of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. Muday 9200 Liberty Road, Randallstown, MD 21133 233. Par 1. Enter the disease, or complications that valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 17-17 Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day sate has been signed by the page 2 should be detached in 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? performed 2 🗌 No Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) KSRAO.M.O. 0 43462 SEPTEMBER 2 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 🚶 😘 🔭 😙 🤝 12 andally toon Cailt 17 # 201 51133 610 32. Registrar's Spinature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Month 8:45AM eplember 2010 Medical Facility Name (if not institution County of Death Examiner giv 4b. City, Town, or Location of Death Date of Birth 9. Birthplace (State or Foreig **Funeral** 1 - M 2.8 F Month, Day, Months Hours Min. Country) 85 20 2874 Director Usual Residence of Decedent 28a-f shor 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits the Maryland Director 1 Yes 2 No Pasadena MD Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1220 Markham Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3. Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within and Mental Hygiene. Elementary/Seconday (0-12) 10 Telephone Operator TBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Henry Harding Margaret Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1220 Pasadena, Charles Herbert - Son Markham Dr. MDBaltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9/7/10 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem Gdn*s* Sykesville, 22. Name and Address of Facility GJ Gonce Funeral Home, P.
169 Riviera Dr. Pasadena, MD 21122 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death 507813 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 534 Withou 771Lin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 년 9 ☐ Unknown sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed<sup>a</sup> After this certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To I 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Director Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral Discompleted filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and Atle of

Registrar
DHMH 17 Rev 7/2009

State

30. Name and add

31. Date filed (Month, Day, Year)

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ess of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virginia Henning **Eleanor** September 7:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Hummingbird Manor Assisted Living Aberdeen Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Feb. Day, Year 1922 Maryland Director 216-12-2440 Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Harford 1 Yes 2 No Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21015 Hamlet Place South USA 1803 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black. White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other t any injury or other traumatic event, the once. County Government Executive Secretarv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ella May Lamkin John P. Durkee Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig Code) 1803 Hamlet Place South, Bel Air, MD 21015 Diane H. Sengstacke / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 9-8-10 Bel Air, Maryland Carmel Cemetery <sup>22</sup> Name and Address of Facility McComas Funeral Home, P.A. <u>1317 Cokesbury Road, Abingdon, Maryland</u> 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart faildre. List only one cause on each line. Immediate Cause (Final Altheiner Onset and Death ementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Dav Year Pregnant at time of death 5 Other (specify) 2 1100 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Yes 2 1 2 🗌 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No 4 Nursing Home 5 Residence 6 Nother (Speciff) Asst. Living ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No ; after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year)
07/04/2010 29b. Signature and title of certific 135012 W. MacPhail Nd. Bel Air, Md. 21014 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) MO LYNLH Kevin

31. Date filed (Month, Day, Year)

2. Registrar's Sign

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bertha Mary Hasenei 2010 September 1:58 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Aug. 14, Year 1919 1 🗆 M 2 🔀 F Hours Maryland Director 212-09-7475 91 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show lury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Baltimore 1 Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? oy Funeral 21234 USA 2115 Park Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Nidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth (nmn) Friese Henry (nmn) Conrad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4040 Gravel Hill Road, Havre de Grace, MD 21078 Mark Hasenei / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Service Corp. Hilltop 9-8-10 Towson, Maryland of F Aral Service Lenses 22 Name and Address of Facility Home, 1317 Cokesbury Road, Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician. Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No
9 ☐ Unknown Pregnant at time of death Other (specify) signed by the aid be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Inpertient Hospital Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending .\_..natural ☐ Accident ☐ Suic! Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WIS 0 V 32. Registrar's Registrar

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	For State Registrar		3	state of	iviaryia		partment of l e <i>rtificate of l</i>		ivientai Hy	gien Reg. N		1.0	07000
Physicia	n/	1. Decedent's Name Frank			oog Tw					2. Date of De	eath	20	Year	3. Time of Death
Medic	al	4a. Facility Name (if	John not institution		nes Jr			4b City Town o	or Location of Deat	Septem		3, 2	Year 010	2:00 A M
Examin	er	2218 Que		-		C1)		Fallst			1	ord		
Funeral Director		5. Social Security No. 216–18–41	umber 115	6. Sex		. Age (In yrs. 87	last birthday Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth 20 <sup>Yea</sup> r,	1922	g. Birth	place (State or Foreign Land
nd ihow at	'n	Usual Residence of 10a. State	Decedent 10b. County			10c. C	ity, Town or	Location		<del> </del>		-		10d. Inside City Limits
Maryla 18a-f s stified	rect	Maryland	Harfor	đ		F	allsto	on						1 🗌 Yes 2 🙀 No
th the	Funeral Director	10e. Street and Nun	mber					10f. Zip Code			_	Citizen of W	hat Cou	ntry?
ath wir	nner	2218 Que	eensbur			ent Ever in U	S 1'	21047 3. Was Decedent of F	Hispanic Origin2 (9	pacify Vas or No-		SA	0	1
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Marri 3 🔀 Widowed		ed	Armed Force  1 X Yes 2  If Yes, Give  Year or Date	es? 2 🗌 No	.3,	If Yes, specify Cub	an, Mexican, Puer				, White,	
2 hour "natu	plet	(Spe	15. Deceden				16a. Dec	cedent's Usual Occup re kind of work done	pation during most of wo	rkina	16b.	Kind of Bu	siness In	dustry
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and 2 Health tem 2		Darlene 20a. Method of Disp		/ Da	ughtei		2025	Brandy position (Name of	Drive, F	orest Hi		Mary Location -		
Page 1 ent of nt: If if			☐ Cremation 5 ☐ Other (S)		oval from S	tate	cemetery, ci	ematory or other pla	1				-	
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Physician/ Medical		disease or condition resulting in death)		a	Due to (or	as a consec	juen e of):	Renal	Dis	2436			+	3 months
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executed an and rial-transi	Exar	Cause (Disease or that initiated events resulting in death) I	s	c	Due to (or	as a conse	quence of):							
ath certificate be executed attending physician and for use as the burial-transit	lical			d										
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ath ce attend for us	cian,	23b. Was decedent in the past 12 r	months?	1	1 🔲 Live Bi	ome of pregr rth 2  Fe ant at time of	tal death 3	Ectopic pregnan Other (specify)	су			23d. Date Mor		rery Day Year
the de by the ached	hysi	1 Yes 2 General			g 🗌 Unkno									
law requires that the de has been signed by the le 2 should be detached		Part II. Other signif	ficant condition	ns contrib	uting to dea	ith but not re	sulting in the	e underlying cause gi	iven in Part I.			_/		he cause of death?
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The law i cate has k page 2 s	Completed by										psy ormed?	P	rior to co eath?	psy findings available ompletion of cause of
an: Th tificate tor, pa	a l	25. Was case referre	ed to medical	Т				26. P	lace of Death (Che	1 🗌 Yes	2 🖭	Vo 1	∐ Yes	2 🗆 No
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ending P eath. or; After the	Certificate:	27. Manner of Death  1 □ Natural  2 □ Accident  3 □ Suicide	h 5  Pending Investige 6  Could n	ation	28a. Date of (Month,	injury Day, Year)	28b. Time injury	wor		28d. Describe l	how inju	ary occurre	d	
tal or Att rs after d al Directo led in by t		4 🗌 Homicide	determi	ned 2	building	, etc. (Speci	fy)	street, factory, office		City or Tox	vn, Stat	e)		l Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2 only one) 3	Medical Ex	(aminer: (	On the basis	of examination	on and/or inv	h occured at the time estigation, in my opini e, death occurred at the	on, death occurred	at the time, date a	and place	e, and due	to the ca	use(s) and manner stated.
vit Cor.		29b. Signature and	title of certifier	n				29c, Licens	35012		0	ate signed	4/	2010
10x1		30. Name and addre			eted cause	of death (Ite	m 23a) (Type	Print) W. M	ne Phail	1 Rd. !	Be/	Air	My	1. 21014.
Stat Registra		31. Date filed (Mont)			2. Reg	istrar's Sign	ure for	who!						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Day QG Physician/ Year 0414 M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ar Versit more 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 2 🗆 F Months Hours Min Director 900 Usual Residence of Decedent 28a-f show 10b. County th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside Pity Limits Director Marylana 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Funeral lashin 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busin (Specify only highest grade completed) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last Mother's Name (First, Middle, Maiden Surname, ဂ္ vonne Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai Saraza Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other 4 Donation 5 Other (Specify) 21. Signature of Funeral Ser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appro imate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit The law requires that the death certificate be executed Due to (or as a consequence resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ပ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 🗀 Pending 1 Natural injury work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as the time, date and place, and due to the cause(s) and the time, date and place are the time, date are the time, date and place are the time, date are the time, (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 1760617880 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene St. 'e State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) September 5 2010 Year **Physician** 5:34 a.™ Mar /Medical 4c. County of Death 4b. City, Town, or Location of Death RandallS78 W 4a. Facility Name (If not institution, give street and number) Examiner nesis Randall Stown Center Baltimore Count If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 NC Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funera Days Hours 238-58-555 1 □ M 2 🗗 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at MD Baltimore Randallstown 1 ☐ Yes 2 No Director 10e. Street and Number 9109 Liberty Road 10f. Zip Code 10g. Citizen of What Country? 211.33 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: African-American 3 Widowed 4 Divorced Year or Dates: permit. Pages 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" any Injury or other traumatic event, the Medical Execute. 'natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Nursing Aid Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elijah Ward Rosa Gordon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7802 Nashua Circle, Windsor Mill, MD 21244 Elden Louise Thampson/Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hamilton Cemetery 9-11-2010 Wilson, North Carolina 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name and Address of Facility While Funeral Home P.A. of Falto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition resulting in death) Vas culo **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Nephopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 **N**O 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 | Yes 2 | Xo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a Date of Injury 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending (Month, Day Year) 5 Pending investigation 1 Natural 1 Yes 2 No within 24 hours after death. To the Funeral Director: A completely filled in by the fo 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D47683 Mille Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Belmer MD 2835 Smil Ave Smi Registrar's Sign State Registrar

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		•	For State Registrar		State of M	/larylanc		irtment of tificate of			fental Hy	/giene Reg. No	201	n	27995
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Se	Funeral Director		5. Social Security No.	4550	Sex 7. A	ge (In <i>yrs. Ia</i> s 7.8	t birthday) Yrs.	If Under 1 Yes Months Day		rs Min,	8. Date of Bi (Month, Di 03 2	rth ay, Year) 9 3	9. 6	Birthplace Country)	(State or Foreign
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گر 21215	hin 72 ne. <b>than "</b> ı ıe <b>Med</b>	Completed	Elementary/Sec	onday (0-12)	grade completed) College (1-4 or	5+)	life, DC	ind of work don NOT use retire	ed)	nost of worki	ng				
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P7 Balt	permit. Depart Import any inj		21. Signature of Fur	neral Service Lice	March		22. Ma	Name and Add	ress of Fa	est Ave	Balt	imor	re. Md	212	215
			23a. Part 1. Enter t	the disease, or co	mplications that cause one cause on each lir	ed the death.								App	roximate val Between
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Box 68760	eath certifica attending p	an/M	IF FEMALE: 23b. Was decedent		23c. If yes, outcome			Ectopic pregna	ancv			116.	23d. Date of c	delivery	8
. <b>B</b> 0	that the death ned by the att e detached for	Physician/Medical	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	-No	4 Pregnant 9 Unknown	at time of de		Other (specify)					Month	Day	Year
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rds	v requires the been signer should be considered	eted	Liver	mer	-0121-04-01						1 L				4 Unknown
Division of Vital Records,	The lav ate has page 2	Completed	pr	may							auto		prior to death?	o complet	ion of cause of
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of V	g Phys er this ieral di	te: To	27. Manner of Death	n	1 Inpa 28a. Date of inj (Month, Da	tient 2 E	R/Outpatient 8b. Time of injury	28c. Inj	4 ∟ ury at		me 5 🗌 Resi 28d. Describe			ecify)	
io.	itendin death. tor: Aff the fur	Certificate:	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigati 6 ☐ Could not	ion	= +		M 1	ork? Yes 2						
Divis	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,		4  Homicide	determine	28e. Place of In	jury - At hom tc. <i>(Specify)</i>	ie, farm, stre	et, factory, offic	9		28f, Location ( City or To			Rural Rout	e Number,
	Hospi 24 hours Funera leted fill	Medical	(Check 2	Medical Exa	nysician: To the best o miner: On the basis of urse Practioner: To the	examination a	and/or investi	gation, in my op	nion, death	h occurred at	the time, date	and place	and due to the	e cause(s)	and manner stated.
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	Stat Registra	e ar	31. Date filed (Month	P 0 8 20	10 Amegist	rar's Signat	par	Kal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gary Johnson	1- For State Registrar	State o	f Maryland / I	Department o <i>Certificate o</i>	f Health and Ment f <i>Death</i>		201( eg. No.	2799
Physician Medical Examine	1. Decedent's Name	(First, Middle,Last)	Johnson	~		2. Date of Dea Month August 31	th Day Year	3. Time of Death 1530 hrs
		f not institution, give s	street and number)		4b. City, Town, or Location of Baltimore		4c. County of Deat	A
Funeral Director	5. Social Security N	umber 6. Sex 7291 1 1 1		In yrs. last birthday)	If Under 1 Year If Under Months Days Hours	24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bi Forei	
and is show any	Mental	Decedent 10b. County	10	Oc. City, Town or Local	Battime	re		10d. Inside City Limits 1 Yes 2 No
the Marylanc is or 28a-f sh utified at once		Pennsylv	ania A	R.	10f. Zip Code		Og. Citizen of What Cou	ntry?
5-0036  Isolate with the Maryland stylene death with the Maryland stylene. Other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once. Commisted by Firnaral Director	3 VVidowed	d 2 Married 4 Divorced	Yes, Give Year or Dates:	No If Y	s Decedent of Hispanic Origines, specify Cuban, Mexican, I	Puerto Rican, etc.)	White, etc. Specify: BI	ican Indian, Black,
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exal	Elementary/Seco	ndary (0-12)	highest grade complete (1-4 or 5+)	during m	t's Usual Occupation (Give ki ost of working life. DO NOT u	se retired)	16b. Kind of Business/	,
D 21215-0036 should be filed within 7 should be filed within 7 is manked other than 1 is marked other than 1 is Medical COMPINE TO Be Comple	James 19a. Informant's Nat	Johnson me/Relationship (Typ				Name (First, Middle, I Ne McA- per or Rural Route, Nur	eill	e, Zip Code)
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	20a. Method of Disp 1 Burial 2 4 Donation 5	Cremation 3	Removal from State	crematory or ot	ition (Name of cemetery, ner place)  Cemetery lame and Address of Facility	Date  Roker Eu	Battimore	Town, State  Maryland  A 21229
Physician  Examiner	failure. List only Immediate Cause (F	y one cause on each inal disease a	line.		72 Frederick ne mode of dying, such as car rediovascular D		Himor, M est, shock, or heart	proximate Interval Between Onset and Death
aminer	or condition resulting Sequentially list cor if any, leading to im- cause. Enter Undar (Disease or injury the events resulting in co	iditions, b	ue to (or as a conseque to (or a) conseque to (or a	uence of);				
60, e be executed ysician and burial - transit	X UNPENDED	d	AMENDED 23a	,27 per me	g907 9-10-10	vt		
tox 6876 eath certificat attending phi for use as the control of t	23b. Was decedent past 12 months?	pregnant in the	23c. If yes, outcome  1 Live birth 4 Pregnant at tim 9 Unknown	2 Fe	tal death 3 Ectopic p	oregnancy	23d. Date of deliver Month	) Day Year
s, P.O. Board the desires that the designed by the desired of the desired of	Part II. Other signif	icant conditions c	ontributing to death be	ut not resulting in the u	nderlying cause given in Part	1 Yes	bacco use contribute to	pably 4 🗸 Unknown
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the d within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached ledical Certification: To Be Completed by Phylectical Certification: To Be Completed by Phylectical Certification:		and to modical			26 Place of Death (C	1 Yes	sy prior to o med? death?	topsy findings available completion of cause of
F Vital Physician rithis cert al directo	examiner? 1 ✓ Yes 2	No Hos	spital: 1 Inpatient		3 DOA Other4 1	Nursing Home 5	Residence 6 🗸 Other	: Scene
Sion of ktending i death. ctor: After y the funer	.   27. Manner of Death	5 Pending Investigation	28a. Date of Injury (Month, Day,Year)		1 Yes 2 N	No	now injury occurred	
Division c spital or Attending tours after death. neral Director: Af filled in by the fun Certification	3 Suicide 4 Homicide 29a. Certifier	6 Could not be determined	(Specify)	y - At home, farm, stree	t, factory, office building, etc.	28f. Location (S or Town, S	street and Number or Ru tate)	ral Route Number, City
To the Ho within 24   To the Fu completely	(Check only one) 2 V	Medical Examiner: 0			red at the time, date and place on, in my opinion, death occu		and place, and due to th	e cause(s)
	hing	ad,	NS		29c. License number O.C.M.E.		29d. Date signed (Mod September 1, 20	
all but	Ling Li, MD	Assistant Med		111 Penn Stree	t, Baltimore, MD 2120	1		
State Registra	e 31. Date filed (Monti	i, Day, Year) EP 0 8 201	32. Registraris	Signature .	we			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#30perDVR.G907,978/2010,WS

State of Maryland / Department of Health and Mental Hygiene 0 | 0 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Physician 10:27 PM September 04, 2010 Dennis M. Knauer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Memorial Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex ★□ M 2□ F 7. Age (In vrs. last birthday) **Funeral** Days Months Yrs. 218-56-0419 59 September 20, 1951 Baltimore Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f ahov th and Mental Hygiene. ?7 is marked othar then "natural", or Items 23s or 28s-f ahov traumatic avent, the Mudical Examinar must be notified at 1 Yes 2 No Baltimore Baltimore County Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7208 Willowdale Avenue 21206 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Black, White, etc. XXNever Married 2□ Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Date 1972-1975 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Legal Service Assn. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis J. Knauer Katherine Welsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7873 Pepperbox Lane (Brother) MD Philip R. Knauer Pasadena 21122 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 7,2010 Baltimore, MD. Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lassahn Funeral Home 7401 Belair Road Baltimore, MD. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SEFTIC SMOCK Proysician /Medical resulting in death) Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transil resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No certificete 1 ☐ Yes or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours efter death.

To the Funeral Diractor: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) SEP 0 8 2010

Khalid Puthawala

29b. Signature and title of certifier

PCCAB 602 S. Atwood Rd. #206 Bel Air, MD 21078 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

00

29d. Date signed (Month, Day, Year)

9-5-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 25 2010 3.50 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Elizabeth's Nursing Home Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth Nov 25, 1916 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Maryland Director 218-03-1523 93 Nov Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If them 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Evaminar mand Landon. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? Be Completed by Funeral 5721 Edmondson Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 X Widowed 4 ☐ Divorced Year or Dates un 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk machinest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Raymond J. Kirby Lillian Stark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramsgate Court Baltimore, MD Carol Willasch/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Dother (Specify) Signum al Service Licen Conal d'S State and descript Board 655 W. Baltimore street rector Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Ad: Physiciani several Daws disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \ No this certificate 1 Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Certificate: To 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 2 🗌 No Investigation Accident the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed

State Registrar (Check

only one

29b. Signature and title of certifier

Date filed (Month, Day, Year)

SEP 08

2010

leted cause of death (Item 23a) (Type, Print)

. Registrar's

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27999 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 539 PM MARY MAGDALINE KEENER orthopy Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ta mond. HM | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 6, 1952 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Maryland Director 5-60-1001 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at Director 28a-f 1 Yes 2 TNo Edgewood Marvland | Harford 10f, Zip Code ò 10e Street and Number 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a USA Edgewood 1608 Ashby Square Apt. C death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 'natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates White Completed 3 ☐ Widowed 4 😾 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Factory Worker Wire Die Manufacturer 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jane Madeline Stinebaugh John Alfred Dix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1608 Ashby Square, Apt. C, Edgewood, Maryland 21040 Ada Perkins / Partner 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Towson, Maryland 9-10-2010 Hilltop Servcie Corp 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. Kathleen Dantivasci 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ 4 disease or condition Medical resulting in death) Examiner Due to (or a a consequence of) Sequentially list conditions Examine Due to for as a consequence of: if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and -transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate I 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 1 Tes 2 0 No 1 Minpatient 2 ER/Outpatient 3 DOA 은 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Director: / thin 24 hours after de the Funeral Directo mpleted filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2

To the F

complet 3 Detrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hV

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland				ental Hygie	<sup>ene</sup> 201	0 28000
		1	State Registrar  Decedent's Name (First, Middle, Last)	Cen	tificate of De	eatn	2. Date of Death	J. No.	3. Time of Death
	Physician	1/	GLORIA KNIGHT				Month?	03/2	1430 M
	Medic Examine		A. Facility Name (if not institution, give street and number) HOSPICE OF THE CHESAPEAKE		4b. City, Town, or Lo	cation of Death		4c. County of De	AA CO.
	Funeral Director	5	. Social Security Number  230-90-4792  6. Sex 1 □ M 2 □ F  7. Age (In yrs. last	birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth 08-13-1		Birthplace (State or Foreign Country) VA
	or at		Usual Residence of Decedent   10a. State   10b. County   10c. City,	Town or Loc	ation				10d. Inside City Limits
	Aarylar 8a-f sl tified	Director	MD PRINCE GEORGE	CAPITO		S			1 🗆 Yes 🌠 No
	a or 2 be no		i 0e. Street and Number		10f, Zip Code	207/2		g. Citizen of What ${f USA}$	Country?
	th with ms 23 must	Funeral	1113 BROOKS ROAD 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hisp	20743 panic Origin? (Spe	cify Yes or No-	14. Race - Ar	merican Indian,
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 20 or 2	ठ	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 M No If Yes, Give Year or Dates.	1	Yes, specify Cuban,  Yes 2 No	Specify:		Specify:	BLACK
2-0	2 hour	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupati kind of work done dur O NOT use retired)	ion ring most of worki		6b. Kind of Busine	ss Industry
72	ithin 7 iene.	Con	Elementary/Seconday (0-12) College (1-4 or 5+)		UTIVE ASSI				OF COLUMBIA
pd	filed w al Hyg d othe event,		17. Father's Name (First, Middle, Last)				e (First, Middle, Ma		
yla	should be file and Mental 7 is marked of raumatic eve	잍	ALVIN J. WILSON  19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ng Address (Street and		NEDDINGT(		Zip Code)
Ma	12 shou lith and 27 is m r traum				BROOKS ROA		COL HGHTS	s, MD 207	43
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once.		200. Motified of Disposition 2 Pamoual from State Cel	metery, crer	esition (Name of matory or other place) HAPEL BAPT	PTCT OO	/09/10	LAWRENCE	20743 VILL, VA
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	22	2. Name and Address L701 LAURE	NS ST.,	BALTIMOR	E, MD 21	217
	Fnysician Medical Examiner	Examiner	23a. Part & Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence of):	ANCER	30011 43 541 541			Approximate Interval Between Onset and Deat
D.	te be executed iysician and ne burial-transi	dical Exar	Cause (Disease or iinjury that initiated events resulting in death) Last  C. Due to (or as a consequence of the consequence of	ence of):					
Box 68760	ath certifical attending ph for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 → No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date o Month	f delivery Day Year
s, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resu	ulting in the	underlying cause give	en in Part I.	23e. Did tob	£	te to the cause of death?  ☐ Probably 4 ☐ Unknown
Division of Vital Records,	ne law requi e has been age 2 should	Completed by					24a. Was ar autops perforr 1  Yes	by prior dear	e autopsy findings available r to completion of cause of th? I Yes 2  No
al B	ian: The	Be C	25. Was case referred to medical examiner?		Otho	ace of Death (Che		- <del>V</del> /	TATE
of Vit	ng Physic fter this couneral dire	은	1  Yes 2 No Hospital: 1 Inpatient 2    27. Manner of Death New Natural 5 Pending Pending	28b. Time injury	of 28c. Injury	at		ow injury occurred	Specify) [ ·· L L
ivision	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:	Medical Certificate:	2/ Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, s			28f, Location (St City or Town	treet and Number on, State)	or Rural Route Number,
۵	Hospital 24 hours Funeral eted filled	ledical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowl of the basis of examination of the basis of my knowl of the basis of examination of the basis of examination of the basis of my knowl of the basis of examination of the basis of the basis of the basis of the basis of examination of the basis of				ace, and due to the	cause(s) and mann	er as stated.
_	To the within To the compl	Σ	29b. Signature and title of certifier	MIS	29c License		8	29d. Date signed (A	3//O
	A		30 Name and address of person who completed cause of death (Item SUSAN / RIEGER, MI)	23a) (Type	Print) Cfen	se Hw	y Aun	apolis,	Mis 21401
	St Regist	ate	31. Date filed (Month, Day, Year) SEP 0 8 2010 SEP 0 8 2010	ture	,				